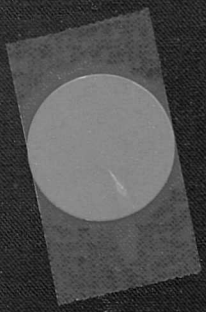


GUY'S
HOSPITAL
GAZETTE.

NEW SERIES

VOL. 13.

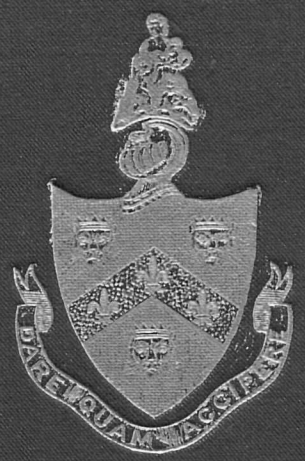
1899

GUY'S HOSPITAL GAZETTE.

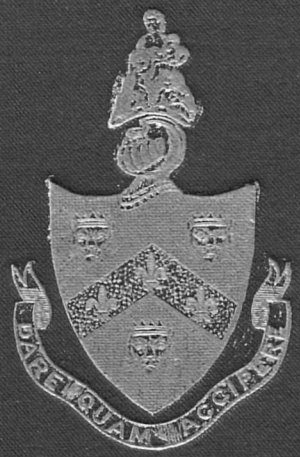
NEW SERIES

VOL. 13.

1899



Guy's Hospital Gazette.



Guy's Hospital Gazette.

The Wills Library
Guys Hospital Medical School
London, SE1 9RT

107532
2

GUY'S HOSPITAL GAZETTE.

VOL. XIII.

NEW SERIES.

1899.

PAGE

CLINICAL LECTURES—
Mr. Davies-Colley—
Fracture of Patella 433
Renal Calculus 504
Mr. Dunn—
Pylorectomy 375
Growth of the Large Intestine 423
Dr. Galabin—
Four Cases of Hysterectomy for Fibroid Tumour 113
Mr. Clement Lucas—
Two Cases of Hernia 104
Dr. Newton Pitt—
Pneumothorax 57
Abdominal Tumour (see errata p. 109)... 69
Two Cases of Cerebral Cortical Lesions 201
Summer Diarrhœa in Children ... 477, 497
Dr. Pye-Smith—
Intestinal Obstruction 1
Dr. Savage—
Alcoholic Insanity 353
Dr. Shaw—
Sarcoma of the Stomach 261
Perforated Gastric Ulcer 285
Mr. Symonds—
Prognosis in Rectal Cancer 242
Dr. Taylor—
Rest and Digitalis in Heart Disease ... 181
Two Cases of Bronchiectasis 221
Dr. Washbourn—
Scarlatinal Arthritis 309
Antitoxin Treatment of Diphtheria ... 330
Dr. Hale White—
Fibroid Disease of the Lung 21
Carcinoma of the Stomach 93
Alterations of Weight by Diet 41
Clinical Medicine, Last Hints on 373
Research Association Circulars ... 104, 126
Clowes, Dr. Ernest F., An Operation in a Country Practice 234
CLUBS—
Athletic, Guy's Hospital 281
United Hospitals 305
Bicycle 40, 284, 328
Chess 55, 68, 259, 467, 539
Colonial 250
Contemporaries 469
Debating Society ... 146, 147, 296, 317, 470
Glee 448
Hare and Hounds, United Hospitals 40, 92, 112, 476, 520, 539
Hos-Scho Cricket Club 496
Lawn Tennis 68, 180, 220, 239, 260, 283, 308, 328, 351
London University 54
Rifle 306
Swimming 308

PAGE

CLUBS' UNION—Annual Report and Balance Sheet 232, 404
Council for 1899–1900 304
Notes on the Constituent Institutions of 398
Collins, Mr. V. E., A Case of Cæsarian Section ... 102
Colonial Club 250
Colonnade, The Mosaic Pavement for 125
Colotomy for Growth of the Large Intestine ... 423
Concert, Smoking 517
The, in Stephen Ward 14
Concerts, Christmas, In the Wards 14, 16
Nurses' Choral Society 77, 279
Conjoint Board, List of Examiners 250
Pass Lists 76, 218, 327, 345, 469, 489
Revision of the Schedule of Drugs in Practical Pharmacy Examination 32
Contemporaries Club 469
Co-operation, Medical 236
Corea, Notes from 441
Coroners' Inquests 172, 177
Cressy, Dr. A. Z. C., Midwifery in General Practice 518
CRICKET—
Annual Report of the Hos-Scho Club ... 496
Bowling and Batting Averages for Season, 1899 407
Cup Ties 258, 282
List of Matches, 1899 219
Matches—
v. Ashby-de-la-Zouch 259
v. Beckenham 239
v. Brentwood 306, 327
v. Croydon 238
v. Crystal Palace 219
v. Dunstable Grammar School 327
v. Eastbourne 283
v. Hornsey 219
v. Reigate Priory 258, 306
v. St. Thomas's 282
v. Surbiton 238
v. Waldegrave Park 219
v. Westminster 258
Past v. Present 282
Crowning, On 152

Davies-Colley, Mr. J. N. C., Fracture of the Patella 433
Renal Calculus... 504
Deaths 40, 92, 112, 160, 180, 200, 260, 284, 308, 476, 520, 540
Debating Society—Annual Dinner ... 296, 317
Ladies' Night 147, 176
Secretary's Appeal for Support 448

PAGE

DEBATES—
"That the Policy of England, both in Egypt and in China, should be one of fearless expansion" 53
"That this Society deplores the existence of the halfpenny newspaper" 146
"That the Tsar's Peace Proposals should receive the warmest support" 147
"That the time has now come for the abolition of the South African Republic" ... 470
Decoration. H. A. Moffat, C.O.S... 476
De Gustibus. A Tragedy 428
Dental Appointments 20, 160, 280, 432
Cyst, Case of 35
Museum, Recent Additions to the ... 234
Pass Lists 228, 513
School, Course of Study at the 393
DENTAL SOCIETY—
Annual Dinner 78
List of Officers 247
Meetings 32, 80, 152, 212, 514
Papers read before the Dental Society—
Extractions. By Mr. F. W. Garman ... 32
A few Considerations on Crowning. By Mr. C. S. Morris 152
The Adaptation of Artificial Dentures. By Mr. J. L. Wartski 212
Presidential Address. By Mr. A. E. Baker 514
Dental Students. Notes of an Introductory Lecture to 445
Dentigerous Cyst, Case of 36
Dentures, Artificial, The Adaptation of 212
Diagnosis, Cases for 99, 295, 339, 394, 511
Commentaries on 112, 315, 352, 408, 520
Diarrhœa, Summer, in Children 477, 497
Diet, Alterations of Weight by 41
Diphtheria, Antitoxin Treatment of 330
Dipsomania 360
Direct Representatives' Meeting at Newcastle, The, Lessons of 516
Dispensary Report, The, for 1898 176
Dissect, How to 382
Dunn, Mr. L. A., Pylorectomy 375
Growth of the Large Intestine 423
Durham, Mr. Herbert E., Acute Infection due to Unsound Meat 275
Durham University Pass List 218

Eclampsia, An Unusual Case of 29
Ectopic Gestation of Six Months, A Case of—Death 529
Endowment of the Medical School 329
Elbow-joint, Fracture of, successfully treated on a Hodgen's Splint 339

PAGE

Electrophysiology, the, of Nerve and Muscle, A Lecture on 6
EXAMINATION RESULTS—
Arthur Durham Prizes 126
Beaney Prize 330
Bredin Prize 274
B.S. London 12
Conjoint Board 76, 218, 327, 345, 469, 489
D.P.H. Cambridge 189, 469
Entrance Scholarships 420
F.R.C.S. Edinburgh 442
F.R.C.S. England 280, 442
General Proficiency 170
Golding-Bird Prize 170
Intermediate M.B. London 76, 344
Science 345
L.D.S. London 228, 513
M.B. Cambridge 12, 281
M.B. London 12, 228, 513, 530
M.B. Oxford 12
M.D. Brussels 304
M.D. Cambridge 281
M.D. Durham 218
M.D. London 12
M.D. Oxford 469
M.R.C.P. London 489
M.S. London 12
Michael Harris Prize 170
Preliminary Scientific 76, 345
Test Examinations—Anatomy 64, 65, 218, 327
Chemistry 65
Histology 65
Physiology 65
Preliminary Scientific 64, 218
Treasurer's Gold Medals 274
Wooldridge Memorial 170
Examiners, Lists of, for the Fellowship and Conjoint Board Examinations 250
Extractions 32

Faith, A Bus Driver's Confession of... ... 56
Fawcett, Dr. John, Appointed Assistant Physician 301
Fellowship, The, R.C.S. Eng., List of Examiners for 250
Pass Lists... 280, 442
Fever Instruction under the Metropolitan Asylums Board 431
Fibroid Tumours, four Cases of Hysterectomy for 113
FOOTBALL—ASSOCIATION MATCHES:—
v. Banstead 92
v. Central Technical College 520
v. Charing Cross Hospital 67
v. Christ College, Finchley 452
v. Croydon Park 39
v. Eversleigh 67, 495
v. Ewell 519
v. Felstead School 475

PAGE

ASSOCIATION MATCHES (*continued*).
v. Forest Hill 67, 475
v. Hampstead 539
v. Ipswich 67
v. L. C. C. 476
v. Old Brightonians 111
v. Old Cranleighans 111, 495, 496
v. Old Foresters 135, 539
v. Old Harrovians 451
v. Reading Amateurs 91
v. Reigate Priory 494
v. Royal Military Academy 476
v. St. Bartholomew's Hospital ... 135, 160
v. St. Leonards 495
v. St. Mary's Hospital 136
v. Weybridge 40, 519
Cup Ties 67, 135, 136, 160
Matches for Season 1899–1900 400
Prospects of 432
Review of Season 1898–1899 179
RUGBY MATCHES:—
v. Beckenham 493, 519
v. Bedford 518
v. Blackheath Proprietary School 494
v. Cambridge 450
v. Catford Bridge 493
v. Croydon 38
v. East Sheen 39
v. Kennington 90, 450
v. Lennox 111, 450
v. London Hospital 133
v. London Irish 494
v. Merchant Taylors 494, 539
v. Old Alleynians 451
v. Old Leysians 38, 492
v. Old Merchant Taylors 518, 519
v. Park House 451
v. Polytechnic 539
v. Redhill and Reigate 66
v. Rosslyn Park 66, 493, 494
v. St. Mary's Hospital 110
v. St. Paul's School 451
v. St. Thomas's Hospital 90, 493
v. Streatham 539
v. Southwark 67
v. Surbiton 135
v. Tonbridge School 494
v. Westminster Hospital 494
Guy's and St. Thomas's v. Penarth ... 492
v. Cardiff 474
v. Blackheath ... 538
Cup Ties 90, 110, 133
Inter-Hospital Cup Draw 20
Matches for Season 1899–1900 399
Prospects of Season 1899–1900 431
Review of Season 1898–1899 178
Welcome to Freshmen 407
Winners of the Cup from 1875 to 1899 ... 134

PAGE

Fremantle, Mr. F. E., With the Royal Army Medical Corps in South Africa ... 489, 534
French, Mr. H. S., Congenital Heart Disease ... 521

Galabin, Dr. A. L., Four Cases of Hysterectomy for Fibroid Tumour 113
Garman, F. W., Extractions 32
Gastric Ulcer, Perforated 285
Gazette Committee, The Reconstitution of ... 487
And *British Dental Journal* 176
Students' Number of the 373, 408
Gazette's, From the, Special Pathologist 32, 56, 109, 160, 172, 190, 240, 250, 267, 308, 327, 371, 406, 432, 448, 492, 520, 540
Geology as a Hobby for Medical Men 412
Glee Club, Students' 448
Goodhart, Dr. J. F., Dinner to 229
Elected on the Consulting Staff 301
Gordon, Mr. Robert, Presentation of Prizes at Guy's Hospital 299
Guild of St. Barnabas 420
Guy's Hospital Athletic Club 281
Bicycle 40, 284, 328
"Blue," Award of the 405
Chess Club 55, 68, 259, 467, 539
Christian Union 210, 419
Christmas at 13
Clubs' Union 232
Colonial Club 250
Contemporaries' Club 469
Debating Society 53, 146, 147, 296, 317, 470
Dinner, Annual House 418
Hat-band 258, 304, 324, 344
Historical Notes on 379
Lawn Tennis Club 68, 180, 220, 239, 260, 283, 308, 328, 351
London University Club 54
Medical School, Historical Notes on 379
Nurses' Choral Society ... 77, 279, 431
Officers and Servants' Annual Dinner 110
Pharmacopœia 123, 125
Students' Glee Club 448
Treasurer's Report for 1898 ... 209
Guy's Men, Papers by 37, 74, 80, 101, 124, 174, 190, 210, 240, 249, 308, 318, 339, 380, 397, 430, 447, 469, 473, 496, 508, 527
Guyite Club, Annual Dinner 303

Handley, Dr. W. S., Presentation to ... 510, 533
Hare and Hounds 40, 92, 112, 476, 520, 539
Hat-band, Guy's 258, 304, 324, 344

PAGE

Haven, The,—Hostel Children's Home ... 460, 470
Heart Disease, Congenital 521
Rest and Digitalis in 181
Hemiplegia 208
Henry, Mr. B. F., The late 316, 319
Hernia, Femoral, Two Cases of 104
Herpes Zoster 419
Hind, Dr. Wheelton, Geology as a Hobby for Medical Men 412
Hospital News 27, 48, 75, 98, 120, 144, 173, 188, 207, 227, 247, 268, 292, 312, 335, 364, 428, 439, 459, 484, 527
Hospital Practice, Days and Hours of attendance on 393
Hos-Scho Cricket Club—Annual Report 496
Hostel Children's Home 460, 470
House Dinner, The Annual 418
Hovenden, Dr. G. S., Some Cases of Scarlet Fever 52
Howard, Mr. R., Blood Films 137
Howse, Mr., With, in the Wards of Guy's Hospital 453
Hysterectomy, for Fibroid Tumour, Four Cases of 113

ILLUSTRATIONS—
Abdominal Tumour, Diagram to lecture on 70
Cerebral Hæmorrhage, Diagram illustrating Case of 255
Christmas Decorations... ... ... 13, 15
Cup, The 220 yards 351
Dentigerous Cysts 36
Diarrhœa Mortality in London, Charts showing 480, 481
Electrophysiology, Diagrams relating to Lecture on 7, 8, 9, 10
Garden Party—Prize Distribution 296
Herpes Zoster 419
"Guyoscope, The" 124
Nurses' Recreation Ground, Plan of Club-house 212
Nursing on the Niger 190
"Paki" 449
Pancreatic Inflammation, Six Microscopic Fields illustrating paper on 130
Pye-Smith, Dr. P. H., Portrait of 394
Pye-Smith's, Dr. P. H., last visit to the Hospital as Physician, Photographs illustrating 368, 369
Rheumatism, Diagrams to lecture on 57, 58, 59
Roentgen Rays, The, as a means of Diagnosis, Skiagraphs illustrating paper on ... 460
Rugby First XV. 398
Sarcoma of the Stomach, Microscopic Field illustrating lecture on 264
Stomach and Omentum, Photographs of large growths of, to illustrate Dr. Shaw's lecture on Sarcoma 265
"The Lass that Love's a Sailor" 151
Trendelenburg's Position, Apparatus for ... 175

PAGE

Infection, Acute, due to unsound meat ... 275
Inlays—Errata 37
In Lighter Vein 122, 156, 199, 216, 235, 257, 278, 303, 324, 349, 371, 405, 447, 473, 491, 536
Inquest 172, 177
Insanity, Alcoholic 353
Intestinal Obstruction 423
Intestine, Large, Growth of the 423

Kidney, Stone in the 504
Kirkman, Dr. A. H. B., Roentgen Rays as a Means of Diagnosis 462

"L'Inconnue," Nursing Notes 233, 250, 272, 296, 318
LAWN TENNIS—
The Championship Competition 352
Election of Officers for 1899 68
General Meeting 68
Hints to Players... 180
Inter-Hospital Junior Lawn Tennis Tournament... 308
List of Matches 220
Matches—
v. Addiscombe 240
v. Boundaries 220
v. Chiswick Park 283
v. Gipsies 260, 283
v. Harold 260
v. Hornsey 260
v. Kent... 239
v. Redhill 260
v. St. Bartholomew's 240, 283
v. Staff 308
v. Wanstead 328, 351
Past v. Present 283
L.D.S. Pass Lists 228, 513
Lectures in Medical School, Syllabus of, for Session 1899–1900 381
Library, A, for Nurses 430
Locum Tenens 325, 343, 367, 394
London University Club, Guy's 54
Pass Lists 12, 76, 228, 344, 513, 530
L.S.A., Surgery Examination 124
Lucas, Mr. R. Clement, Two Cases of Hernia ... 104
Lullaby, A 235
Lung, Fibroid Disease of the 21

McGregor, Surgeon G., R.N., Treatment of Blackwater Fever and Malaria 37
Maggs, Mr. W. A., Notes of an Introductory Lecture to Dental Students 445
Mainly about Nothing 326
Maisey, Dr. C. T. B., A Case of Henoch's Pupura 315
Malaria, Examination of Blood Films with reference to 137
Treatment of 37

PAGE

Marriages 20, 40, 92, 112, 136, 160, 200, 220, 260, 284, 308, 328, 372, 432, 452, 476, 540
Meachen, Mr. G. N., The Functions and Pathology of the Pituitary Body 83
Meat, Unsound, Acute Infection due to 275
Medical Men, Address to 511
The work of, The Bishop of Rochester on 468
School, The Endowment of 329
Historical Notes on 379
On beginning work in the ... 382
Syllabus of Lectures in the, for Sessions 1899–1900 381
Medicine, Bedside, Last Hints on... 373
Melancholia 357
Metropolitan Asylums Board—Appointments ... 467
Fever Instruction 431, 537
Midwifery in General Practice 518
Milton, Mr. W. L., Pancreatic Inflammation and Hæmorrhage 126
Minchin, Mr. E. A., Resignation of 341
Morris, Mr. C. S., On Crowning 152
Morse, Mr. T. H., Apparatus for Trendelenburg's Position 175
Mugford, Dr. S. A., A Case of Herpes Zoster ... 419

Naval Medical Service 104, 145
Neuritis, Acute Peripheral, A Case of 100
New Year's Eve, 1899 18
Niger, Nursing on the 190
Nothing, Mainly about 326
Nurses' Choral Society 77, 279, 431
Library 430
Recreation Society 77
Nursing News 10, 30, 53, 77, 109, 150, 174, 190, 199, 226, 258, 271, 298, 343, 367, 430, 467, 492, 517, 537
Notes 233, 250, 272, 296, 318, 340, 362, 397, 420, 468, 490, 530
On the Niger 190
Service Reserve, The Army, Regulations for 517

Obituary—
Adams, Dennis 316
Macdonald, Robert Fenton 64
Slater, Leonard 252
Odontome, Follicular 36
Operation, An, in a Country Practice 234
Ophthalmic Out-Patients' Department, Notes from the 50
Ormond, Mr. A. W., Cerebral Hæmorrhage with Retinal complication 254
Out-Patients' Christmas Tea 18, 36, 77, 490
Ophthalmic 50
Oxford University Pass Lists 12, 469

PAGE

Pakes, Mr. W. C. C., Biographical Reminiscences of 448
Examination of Blood Films 137
Pancreatic Inflammation and Hæmorrhage ... 126
Papers by Guy's men, 37, 74, 80, 101, 124, 174, 190, 210, 240, 249, 308, 318, 339, 380, 397, 430, 447, 469, 473, 496, 508, 527
Parry-Jones, Dr., Presentation to 10
Passim. 11, 31, 55, 81, 103, 125, 149, 171, 191, 221, 231, 251, 273, 297, 319, 341, 363, 395, 421, 443, 465, 487, 509, 531
Patella, Fracture of the 433
Pathologist, From the Gazette's Special 32, 56, 109, 160, 172, 190, 240, 250, 267, 308, 327, 371, 406, 432, 448, 492, 520, 540
Patients, Consideration of 344
Perry, Dr. E. Cooper, Appointed Physician to Guy's Hospital ... 301
Appointed Lecturer on Materia Medica ... 279
Pharmacopœia, Guy's 123, 125
Physical Culture 253
Physical Society—
Annual Report 189
Presidents for 1899–1900 189
Presidential Address by Sir S. Wilks ... 409
Papers read before the Physical Society—
The Functions and Pathology of the Pituitary Body. By Mr. G. N. Meachen ... 83
Pancreatic Inflammation and Hæmorrhage. By Mr. W. T. Milton 126
Burns and Scalds. By Mr. F. E. Walker 161, 192
Geology as a Hobby for Medical Men. By Dr. Wheelton Hind 412
Roentgen Rays as a Means of Diagnosis. By Messrs. A. H. B. Kirkman and E. W. H. Shenton 462
Congenital Heart Disease. By Mr. H. S. French 521
Pitt, Dr. G. Newton, Pneumothorax 57
Abdominal Tumour ... 69
Two Cases of Cerebral Cortical Lesions ... 201
Summer Diarrhœa in Children ... 477, 497
Pituitary Body, The Functions and Pathology of the 83
Pneumothorax 57
Presentations 10, 120, 496, 533
Prize Day, 1899 299
Examinations, Notice of 79
Arthur Durham 126
Beaney 330
Bredin 274
General Proficiency 170
Golding-Bird 170

PAGE

Prize Day, 1899 (*continued*).
Michael Harris 170
Treasurer's Gold Medals 274
Wooldridge Memorial 170
Purpura, Henoch's, A Case of 315
Pye-Smith, Dr. P. H., Intestinal Obstruction ... 1
Elected on the Consulting Staff 301
Last Visit as Physician ... 368
Last Hints on Bedside Medicine... 373
Pylorectomy 375

Raphael, Mr. H. L., Death of 211
Ray, Dr. E. R., Presentation to 120
Recreation Society, Nurses' 77
"Religio Medici." Address to Medical Men ... 511
Renal Calculus 504
Reredos, Chapel, Decoration of 158, 176, 198, 217, 272
Research, Scientific, Grants for 236
Reviews—
Boyle & Son: Natural and Artificial Methods of Ventilation 471
Browne, Oswald, M.A., M.D.: Some Thoughts about Nursing 238
Care of the Dying 238
Caton, Dr.: The Temples and Ritual of Asklepios at Epidaurus and Athens 369
Cheyne and Burghard: Manual of Surgical Treatment 237
Churchward, Albert, M.D.: Origin and Antiquity of Freemasonry 253
Clarke, Dr. J. Jackson: A Text-book of the Pathology and Treatment of Deformities... 538
Climate: A quarterly Journal of Health and Travel 472
Dakin, W. R., M.D., F.R.C.P.: A Handbook of Midwifery 370
Fitzgerald, John, L.D.S.: Pyorrhœa Alveolaris 371
Foster, Sir Michael: Claude Bernard ... 472
Gant's Guide to the Examinations of the Conjoint Board 30
Gould, G. M., M.D.: A Pocket Medical Dictionary 30
Larking, A. E., M.D.: Notes on Folkestone 471
Lückes, Eva, C. E.: General Nursing ... 30
Muir and Ritchie: Manual of Bacteriology 406
Newsholme, A., M.D.: Vital Statistics ... 406
Paget, Stephen, F.R.C.S.: Essays for Students 30
Pedley, R. Denison, F.R.C.S., L.D.S.: The Hygiene of the Mouth 370
Pick, Thomas Pickering: Surgery: A Treatise for Students and Practitioners 472
Slater and Spitta: An Atlas of Bacteriology 124
Stewart, Isla: Practical Nursing 471

PAGE

Reviews (*continued*).
Thompson, John, M.D., M.R.C.P. Lond.: Guide to the Examination and Treatment of Sick Children 237
White, W. Hale, M.D., F.R.C.P.: Materia Medica, Pharmacy, Pharmacology, and Therapeutics 452
Whitelegge, B.A., M.D.: Hygiene and Public Health 406
Williams, Dawson, M.D., F.R.C.P.: Medical Diseases of Infancy and Childhood ... 237
Year-book of Treatment, 1899 237
Rifle Association—
United Hospitals v. Hon. Artillery Co. ... 284
Cup Team for 1899 ... 306
Rochester, Bishop of, on Hospital Work ... 468
At the "Haven" 478
Roentgen Rays as a means of Diagnosis ... 462
Royal Army Medical Corps, With the, in South Africa 489, 534
Royal College of Physicians of London—
Examination for Diploma in Public Health 534
Pass List 489
Bradshaw Lecture 419
Royal College of Surgeons of England—
Bradshaw Lecture 503, 513
Pass Lists 228, 280
List of Examiners 250
Notices of Lectures 64, 102
In Verse 303
Royal College of Surgeons, Edinburgh, Pass List 442

St. Barnabas, Guild of 420
Sandow's System of Physical Culture 253
Sanitary Science, L.C.C., Scholarships in ... 230
Sarcoma of the Stomach 261
Savage, Dr., Alcoholic Insanity 353
Scarlet Fever, Some Cases of 52
Scholarship, The Beaney 446
Scholarships in Sanitary Science 230
Entrance, Results of Examination 420
Scientific Research, Grants for 236
Scurvy, On the Decline of 320, 345
Sells, Dr. C. J., A Case of Ectopic Gestation of Six Months—Death 529
Serum Treatment of Diphtheria 330
Sharp, Dr. A. J., The Lessons of the Direct Representatives' Meeting at Newcastle 516
Medical Co-operation 236
Shaw, Dr. Lauriston E., Sarcoma of the Stomach 261
Perforated Gastric Ulcer 285
Shenton, Mr. E. W. H., Roentgen Rays as a Means of Diagnosis 462
Silk, Dr. J. F. W., Resignation of... 342
South Africa, With the Army Medical Corps in 489, 534

PAGE

Sport—See under "Athletic," "Chess," "Cricket," "Football," "Lawn Tennis," "Rifle Association," "Swimming," "Water Polo."
Spurgin, Dr. W. H., An Unusual Case of Eclampsia 29
Starling, Dr. E. H., Electrophysiology of Nerve and Muscle 6
Resignation of 341
Stephens, Dr. Lockhart, On Physical Culture ... 253
Stomach, Cancer of the 93, 261, 375
Sarcoma of the 261
Strong, The Battle of the 253
Students' Number of the Gazette 373, 408
Glee Club 448
Summer Diarrhœa in Children 477, 497
Surgery, Smoking in the 448
Swimming Club, United Hospitals 308
Symonds, Mr. Charters J., Prognosis in Rectal Cancer 242

Targett, Mr. J. H., The Axillary Breast... ... 270
Taylor, Canon, "Religio Medici," An Address to Medical Men 511
Taylor, Dr. Frederick, Rest and Digitalis in Heart Disease ... 181
Two Cases of Bronchiectasis 221
Teeth, Artificial, The Adaptation of 212
Testicle, Disease of, Two interesting Cases of ... 533
Testis Ectopia 454
Theatricals, The Probationers' 19
Transfusion 256
Treasurer's Report, The, for 1898 209
Trendelenburg's Position in Abdominal Surgery, Apparatus for 175
Tumour, Abdominal 69

PAGE

Umbrella, An, Story of 428
United Guyite Club, The, Annual Dinner of ... 303
United Hospitals' Athletic Club, Annual Sports 305
Hare and Hounds 40, 92, 112, 308, 520, 539
Rifle Association 284
Swimming Club 308

Vivisection at Exeter Hall 199

Walker, Mr. F. E., Burns and Scalds ... 161, 192
Wartski, Mr. J. L., The Adaptation of Artificial Dentures 212
Washbourn, Dr. J. W., Scarlatinal Arthritis ... 309
Antitoxin Treatment of Diphtheria 330
Water Polo—*Inter-Hospital Competition* ... 308
Way, Dr. Montague H., Two interesting Cases of Disease of the Testicle 533
Weight, Alterations of, by Diet 41
White, Dr. W. Hale, Fibroid Disease of the Lung 21
Alterations of Weight by Diet 41
Carcinoma of the Stomach 93
Wilks, Sir Samuel, Bart., Appendicitis: Not a Novelty 241
Presidential Address to the Physical Society 409

X Rays (see Roentgen Rays).

Contents.

	PAGE
INTESTINAL OBSTRUCTION: Clinical Lecture by Dr. Pye-Smith	1–6
A LECTURE ON THE ELECTROPHYSIOLOGY OF NERVE AND MUSCLE: Delivered by Dr. Starling	6–10
CHAPEL NEWS	10
TESTIMONIAL TO DR. PARRY-JONES AT ALFRETON	10
NURSING NEWS	10
PASSIM	11–12
PASS LIST	12
CHRISTMAS WEEK	13–19
APPOINTMENTS	19–20
SPORT: Football—Inter-Hospital Rugby Football Cup Draw	20

Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well a subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

The charge for binding in blue, with the Arms of the Hospital in gold will be ONE SHILLING AND SIXPENCE.

Calendar of Coming Events.

Jan., 1899.

Sat. 7.—Messrs. Golding-Bird and Dunn's take-in; Drs. C. H. Glenn and A. Densham; Cl., W. H. M. Telling.
1.15, Clinical lecture by Dr. Pitt.
G.H.R.F.C., I., Old Leysians, home.
II., Marlboro' Nomads, away.
G.H.A.F.C., I., Croydon Park, home.
II., Croydon Park, away.
G.H.P.P.S., "The Functions and Pathology of the Pituitary Body," by G. N. Meachen.

Mon. 9.—Second part of Conjoint D.P.H. Exam. begins.

Tues. 10.—Meeting of the Dental Society at 4.30 p.m.
Final Conjoint Exam. begins.

Wed. 11.—1.30, Clinical lecture by Mr. Lucas.
Messrs. Howse and Jacobson's take-in; Drs., H. Braund and P. C. Ingram; Cl., H. L. Eason.
G.H.A.F.C. II., St. Mary's Hospital, away.

Thur. 12.—G.H.M.P.U., Address by Basil Hewer, Esq.

Sat. 14.—1.15, Clinical lecture by Dr. Pitt.
G.H.R.F.C. I., Croydon, home.
II., Croydon, away.
G.H.A.F.C., I., Weybridge, away.
II., L.C.C., home.

Mon. 16.—Preliminary Scientific and Intermediate M.B. Lond. Exams. begin.

Wed. 18.—1.30, Clinical lecture by Mr. Lucas.
Messrs. Davies-Colley and Symonds' take-in; Drs. E. W. Goble and B. W. Moss; Cl., R. H. J. Swan.
G.H.R.F.C. I., East Sheen, home.
G.H.A.F.C. I., Emeriti, home.
II., Balham School, away.

Thur. 19.—G.H.M.P.U., Address by Rev. A. E. Barnes-Lawrence.

Sat. 21.—1.15, Clinical lecture by Dr. Pitt.
G.H.R.F.C. I., Rosslyn Park, away.
II., Rosslyn Park, home.
G.H.A.F.C. I., Reigate Priory, away.
II., Carshalton Park, home.
G.H.P.P.S., "Burns and Scalds," by F. E. Walker.

Guy's Hospital Gazette,

JANUARY 7, 1899.

Intestinal Obstruction.

CLINICAL LECTURE BY DR. PYE-SMITH.

GENTLEMEN,—We have had three new cases of Intestinal Obstruction, which will supplement very well those I described in a previous lecture. You may remember that I then described a case of contraction with puckering and kinking, due to local tuberculous peritonitis, in a boy of fifteen. Mr. Symonds made an abdominal section, removed a caseous gland and divided the adhesions which were tethering down the intestine. The treatment was admirably successful and the patient went out cured. I compared this with a case, many years ago, of a boy a little younger, who came with just the same symptoms. I asked the surgeon to open the abdomen in the hope of removing the obstruction, and we found just the same condition of local adhesions, with a caseous mesenteric gland, which was removed. He died, and I am afraid the majority of such patients will die, whatever is done. Still I think an operation is quite justifiable, and in our recent case we had, as I have said, the happiness of seeing the boy walk out of the hospital cured.

The other case I spoke of in the same lecture was one of cancer of the transverse colon, in a man of only thirty-one—an unusual age for this disease—a patient in whom chronic disease had been allowed to become acute. It had lasted for about a year, and ultimately he had suffered nearly a week of absolute obstruction before he came into the hospital. It was not clear what part of the large intestine was the seat of stricture, so Mr. Dunn thought it advisable to perform laparotomy. A large mass was found uniting the stomach and transverse colon together, and he opened the cæcum. Considerable relief was given, but the patient died thirty hours afterwards.

We have now three other cases. One a case of cancerous stricture again, in a man of forty-seven, occupied the upper part of the rectum, and was treated by lumbar colotomy. Unhappily the case proved fatal. The operation was too long delayed, and the patient was an intemperate man, with considerable bronchitis and a weak heart.

The second was a case of contraction, very like that of the boy I spoke of last time, from puckering and dragging by adhesions. The patient was a young woman of twenty-five. She had developed symptoms of chronic obstruction ever since her first baby was born last spring, and had gradually got worse. While staying at Brighton with some friends, she was very sick and in constant pain. The more she vomited the more they kept on feeding her, until she was brought up from Brighton to the hospital in an almost hopeless state. I will tell you presently what led us to a diagnosis. It was certain nothing could save her life except an operation. That was performed at once, but I suppose we were too late, and she died about fourteen hours after I saw her on admission, or twelve after laparotomy.

The third and last case was one of invagination in a child six months old. That is, as you know, a very dangerous thing. It is not generally difficult to diagnose. Often we can reduce it either by pumping air into the rectum, or by large enemata, and the result may be satisfactory. Unhappily, many cases come too late, when adhesion has taken place, so that if you reduced the invagination you would cause perforation and death. Again, sometimes after an invagination has been reduced once, it returns blood and fæcal matter. Young children are delicate creatures, and if you allow the case to go on twenty-four hours after seeing it, they will probably die, and if you are too long in operating they may die upon the table. So that your treatment must be decided and prompt. If you see a child on the first day of invagination, inflate at once. If that does not succeed after a second trial, it is best, I think, to open the abdomen. The total results, on any plan of treatment, are bad. It was, therefore, a great delight when, after Mr. Symonds opened the abdomen, and reduced the intussusception, the child recovered. The wound is now healed. The child has had a little diarrhœa since, but it is now out of danger.

We have, then, five cases of obstruction; one with dragging from adhesions and contraction —a kind of obstruction described in Dr. Fagge's Paper in our Reports for 1869—in a boy, no doubt of tuberculous origin. In this case laparotomy was performed and recovery ensued. Then there is the case of the young woman which I am going to speak of more particularly, with the same condition, only from pelvic adhesions, and in which laparotomy was followed by death. Then come the two cases of stricture of the colon; one of cancer of the transverse colon which had formed a communication with the stomach, in a man only thirty-one, who died after the abdomen was opened and the cæcum drained; the other, the case in a man of forty-five who had cancer in the upper part of the rectum, and who, after colotomy had been performed, also unfortunately died. Lastly, there is the case of invagination in the baby who has been cured after laparotomy. So that we have in five cases two recoveries. I told you last time that if you have a recovery of 50 per cent. of your cases of intestinal obstruction, you are very much to be congratulated. Here we have two out of five, and if we get one out of five we must be thankful. That is my experience. I trust you will do better.

Now let me speak of these new cases in more detail. I have put up here on the blackboard the different anatomical kinds of intestinal obstruction. First, *impaction*. That is the nearest to mere constipation. Impaction of fæces is constipation of a severe, chronic, troublesome kind, that cannot be overcome by ordinary medicines. There is also impaction of foreign bodies, which may consist of residuum of food, such as husks of corn, or cherry stones, or other foreign bodies. Moreover, *gall-stones* are impacted in the small intestine.

Invagination is a kind of impaction; only the impacting body is a part of the intestine itself, and the pressure of the mesenteric blood-vessels causes strangulation in addition.

Then there may be *external pressure*, squeezing the gut flat. That is not a common thing, but it does occur now and then, more often in the pelvis, where the rectum can be flattened against the unyielding wall of the pelvis.

Again, there is *traction* or *dragging*, causing kinking and twisting of the intestine, and due to peritoneal adhesions. Two examples of this I mentioned just now—one from tuberculous peritonitis, almost confined to patients under adult age; and the other from pelvic adhesions, almost always found in women.

Then comes *stricture*. As Dr. Fagge said, the cases of contraction in the small intestine are clinically much like cases of stricture in the large. Stricture from cicatrix is a very rare thing. The great majority of cases are cancerous

stricture; of this we have two examples—one which I gave at our last lecture in a man of thirty-one, and the one I have just referred to in a man of forty-six.

Next come the acute cases of obstruction with *strangulation*, due to a diverticulum to the appendix, or to a false membrane, a band, or to part of the omentum, any of which may form a band, or an internal hernia. All these act in the same way. A fold of intestine is tightly squeezed and strangled, so that not only cannot the fæces get through, but the blood cannot get through either.

Lastly, volvulus, or "twisting of the gut," as a primary affection almost confined to the sigmoid flexure or cæcum, but often complicates contraction or strangulation.

With a view to diagnosis, one has to know the points which distinguish one form of obstruction from another. I have put them down in the list here.

i. The first point is the probability derived from the *sex* and *age* of the patient. Impaction occurs in women more often than in men, and particularly in women over fifty. Gall-stones are very rare in men, but not uncommon in women over forty. In one case the patient was nearly seventy, and she got well after passing an enormous gall-stone which is now in the museum. You would be surprised at the huge size of some of these. Besides two now in the museum, I saw another passed which was bigger than either, but the patient was proud of it, and all I could obtain was a promise that when she died she would leave it to the museum.

Invagination is most common in children; even babies a few weeks old have had it. But you may see it at any time up to ten years. It is most common in male children, but it is a curious fact that when it does occur in adults it is as common in women as in men.

Obstruction caused by *external pressure* is more frequent in women, because the uterus or ovary is generally the thing which presses. If there is a large tumour or hydatid in the abdomen, it can hardly squeeze the intestine so as to cause obstruction, but a tumour in the pelvis, resisted by its hard wall, can easily do so.

Contraction which causes flattening, kinking, and tethering of the intestine, generally occurs either in boys, or in women during the parturition period.

Cancerous stricture is most frequent after forty in both sexes. Acute strangulation occurs more often in men than in women. The age is generally from twelve, thirteen, or fourteen up to forty. It is not common in little children, and is very uncommon in old people.

Lastly, volvulus. It occurs as a primary lesion in men more often than in women, and only in adult life, usually between forty and fifty.

ii. The next point is the *course*. That is a very important thing. Impaction by fæces or foreign bodies is always chronic; obstruction by gall-stones acute. Invagination is very often acute. It is also remittent; it begins with acute symptoms, but these may pass off, a little fæcal matter is passed, and the child seems relieved, but soon gets worse again and is brought to the hospital. Sometimes the course of invagination is chronic from the first and may last for weeks.

In cases of dragging and contraction, ingravescence is perhaps the more frequent course; the symptoms are slight at first, but gradually get worse, until at last the patient is brought to hospital in a dangerous state. But sometimes it is acute from the beginning. Stricture is always chronic, but sooner or later becomes ingravescent. Strangulation is always acute from the first, and runs a very short course. And volvulus is perhaps the most acute of all.

iii. Again, for diagnosis we must distinguish those cases in which there is mere obstruction without strangulation, from those in which strangulation is present. Obstruction not allowing the fæces to pass, strangulation not allowing the blood to pass. The result of strangulation is gangrene of the gut and fatal peritonitis. The result of mere obstruction, if it is untreated, is ultimately, though it may not be for a long time, ulceration of the intestine above the seat of obstruction, and then perforation. But many cases of pure obstruction at first develope symptoms of strangulation after a time.

iv. As to the seat in which the obstruction is most often found. Impaction of fæces takes place in the sigmoid flexure or rectum, impaction of gall-stones in the jejunum or ileum. Three-quarters of the cases of invagination occur at the ileo-cæcal valve. A tumour seldom causes obstruction, except of the rectum, in the pelvis. Contractions and adhesions are almost confined to the small intestine. Stricture, with very rare exceptions, is found only in the large intestine, most often in the rectum, next in the sigmoid or descending colon, less frequently in the transverse or ascending colon. Strangulation by a band and internal hernia is most common in the ileum, and scarcely ever occurs in the duodenum, or upper jejunum, or in the

colon. Volvulus as a primary condition is most often found in the sigmoid flexure.

Let us apply these facts to the cases we have before us. And first we will take the case of cancer of the rectum. The patient was a man about forty-five. He had been very intemperate, and probably that may have helped towards his final collapse. He had been ill for a long time with slight symptoms, an ingravescent course as usual in stricture of the large intestine, and then severe symptoms came on very rapidly. Colotomy was performed as soon as he came into the hospital, and it gave him considerable relief at first, but he had a bad cough, and died after a few days from syncope.

Post-mortem, we found the cancer to be in the upper part of the rectum, well beyond where the finger could reach. Stricture in the upper part of the rectum and in the sigmoid flexure produce exactly the same symptoms when they are affected. If you find the left side of the abdomen hollow or flatter, and the right side fuller, the stricture is most likely in the upper part of the rectum or in the sigmoid flexure. If you can make up your mind to this, I advise left lumbar colotomy as the preferable operation. But if the stricture is likely to be in the transverse colon, as it was in our former case, you must take the right loin for the seat of operation, and if the stricture can be felt per anum, many surgeons prefer to open the gut in the left inguinal region. You see the diseased part of the rectum—an annular stricture, from an epithelial, cylindrical-celled, malignant growth. There was marked hypertrophy and dilatation of the colon above it. The lungs showed evidence of recent bronchitis; the heart was a little flabby, and there was some atheroma of the aortic valve. So that I think we may say that in this case death was the effect of cancerous stricture of the rectum, occurring in an intemperate man, and left too long before operation. Moreover, the operation itself, however necessary and however skilfully performed, is, to some extent, a source of danger.

Then comes the case of the woman, with puckering and kinking of the small intestine, where it had formed adhesions to the ovary. She was a woman of twenty-five, married, and had her first confinement last spring, and from that time she had suffered from pain in the abdomen with constipation that gradually got worse and worse, in spite of various laxative medicines. Then, I told you she went out of town to get a change of air, and at last came up here in a very grave condition, emaciated, with an enormous tympanitis, and complete obstruction. We could see folds of intestine, three horizontal coils lying across the abdomen, and from time to time, when the bedclothes were lifted, the stimulus of the air set them visibly contracting. The poor woman screamed with the pain of the colic, that is, the cramp, on contraction of the muscular fibres of the intestine. This visible painful peristalsis proved that the obstruction was not recent. She had been suffering for several months, with slowly ingravescent obstruction, during the whole of which time the small intestine had become dilated and hypertrophied, exactly in the same way as the bladder dilates and hypertrophies behind a stricture of the urethra or the left ventricle behind a contraction of the aortic orifice.

It was quite clear that the distended gut was not the colon. The colon when distended usually forms one curved transverse band across the upper part of the abdomen. If very full it bends down until it may form a U-shaped coil with two vertical folds visible through the abdominal walls.

The three horizontal bands stretching across the abdomen could not be the colon; they were certainly distended folds of the small intestine. Therefore the obstruction could only be either the large intestine, near its origin—a rather rare place, particularly about patient's age—or else in the small intestine towards the termination of the ilium.

The probability as to the seat of the obstruction was helped by considering that the patient was too young to have a cancerous stricture, and too old for invagination, of which, moreover, there were none of the characteristic symptoms. Again, the case was not like strangulation by a band. The history was too long. She would not have lived a week, probably, if there had been complete strangulation. So that we put that on one side. Although there had been vomiting, it had not been as early or severe as is usual in cases of strangulation or of volvulus. There was no sign of an abdominal tumour; and it was much too severe a case for impaction. The symptoms pointed to complete obstruction of the small intestine without at present strangulation or peritonitis. So that by exclusion we arrived at adhesions and contractions as the most probable cause of the symptoms. The patient being a woman, we thought of local pelvic adhesions. We had a history which seemed to answer to this hypothesis. Her symptoms dated from her confinement in the early spring; and the ingravescence of her symptoms, terminating in an acute attack, was

just what we should have expected. So that we felt pretty certain that the origin of the illness was in perimetritis after childbirth, and that the seat of obstruction was in the lower half of the small intestine.

Then what was to be done? It was a bad case, almost a hopeless one, and an operation though it gave the only chance of life was in itself a source of danger. Although there was no strangulation, yet the symptoms pointed to obstruction, so long continued, that probably the mucous membrane of the gut immediately above would be inflamed, perhaps ulcerated, and ready to give way, while the retained contents were poisoning our patient. In such cases the immediate object is to relieve the fulness of the intestine above the obstruction, and to do this as speedily and innocuously as possible. I think the best plan is not to explore at all, not to perform abdominal section (laparotomy), but to make a small incision in the middle line, near to the pubes, to open the presenting coil of distended intestine. The lower down it is opened the better, as long as you are above the stricture. This will give immediate relief, and if the patient's state allows it, you may afterwards attempt more.

Mr. Jacobson opened a distended coil in the middle line; an enormous quantity of liquid and fæcal matter poured out with great force from the distended intestine—some pints. That was a very good thing for her, but it came too late. The plan we should have adopted, if the operation had been so far successful, would have been to let her get better after this relief, and then subsequently to explore and, if possible, find and relieve the constriction.

Post-mortem.—We found that the left ovary was enlarged with a fold of the ileum that had become adherent to it, and so bent upon itself that even liquid fæces could not pass through. But even then it was possible to send a stream of water through with force, and without rupturing the gut, so that if the case had been admitted earlier the result might have been different and the patient's life preserved.

Our third case is one of invagination in an infant six months old, a fine healthy-looking child, a boy—as I have already pointed out, invagination is more common in boys than in girls. This child was suddenly taken with vomiting, severe pains, screaming, and pulling up its legs while taking the mother's breast. It got a little better, then became worse, and was brought in (perhaps sooner than many of them) with vomiting, abdominal pain, and passage of mucus and blood from the rectum. From these symptoms you think at once of the probability of intussusception which is the only common form of obstruction at this age. On examining the abdomen, a tumour was found with the characteristic cylindrical shape, and, more important than that, when you grasp it you may often feel it contract under your fingers. The intussusception was felt at some distance from the right of the ileo-cæcal valve, but it had not come down as far as the rectum. There was no doubt about the diagnosis, and I think inflation is quite the right thing to do in early cases like this. But the clinical assistants this time thought they would use injection and used milk.

As it generally happens when either inflation or injection is used in time, this operation was successful; it brought the tumour back from the left to the right side of the abdomen, and made the abdomen very much smaller. But there still remained the lump, though reduced in size. That being the case the most promising treatment was to cut down on the tumour. Mr. Symonds made an incision over the lump, and found there was still a considerable piece of gut which had not been reduced. He manipulated it into its right position, and what I have not known before—but it seems a reasonable thing to do—after the whole thing had been put back for a few minutes, the wound was opened again just to see that the invagination had not returned. Sometimes it goes back as soon as the fingers are taken away. Happily this had not occurred, so the wound was sewn up, and although the child had diarrhœa for several days after, the wound is healed and he is now quite well. That, unfortunately, is not a common result of any treatment. In spite of occasional success, as in this case and in another one which Mr. Hutchinson published, I am afraid most of these patients died after laparotomy, the reasons being that the lesion itself is a complicated one to deal with; secondly, that they are generally not brought till adhesions or even sloughing have begun; and, thirdly, that the patients are so young and feeble that they do not stand either severe disease or the measures employed to relieve it.

Here is a drawing I have brought down which shows the anatomy of intussusception very well. Intussusception is most common at the ileo-cæcal valve, this structure "presenting" all the way to the rectum; next in the small intestine, in the ileum and jejunum; very rare in the large intestine, and perhaps most rare of all through the valve into the cæcum and colon.

Out of these five cases two recovered, which is a good proportion. But notice how uncertain these things are. Two of the fatal cases were stricture of the colon, where colotomy is such a good operation and you expect success, yet both these died; whereas laparotomy in a child with invagination is very dangerous, and yet he recovered.

In the last lecture of the Systematic Course of Medicine before Christmas, Dr. Pye-Smith narrated a case of invagination in his own wards which occurred since the above clinical lecture was delivered. The child was six months old, a previously healthy boy, brought into the hospital the day after a sudden attack of abdominal pain, vomiting and hæmorrhage. A large enema of milk was administered, and the tumour in the abdomen disappeared. Probably the invagination was only partially reduced, for it returned and the child became almost suddenly cold with failing pulse, and rapid death from collapse followed. There was found ten inches of ileum and eight of cæcum and colon involved in the swelling. No adhesions had taken place, and the invagination was reduced by manipulation without rupture.

In concluding the course, Dr. Pye-Smith gave the following means as likely to be useful in future practice.

In observation be careful patient is accurate in details, while not omitting to observe the patient as well as his organs. In obscure and in all chronic cases, take a fresh unbiassed survey after an interval.

In diagnosis be deliberate, often tentative, but never undecided, and when you have determined the seat, the nature, and the origin of the disease, write it down.

In prognosis be truthful but hopeful, and never give up a patient. When most unfavourable, it rests on your diagnosis, and that may possibly be wrong. Never prophesy the time that will elapse before either death or recovery.

In treatment, have an object in view, and do not lightly give it up. Do not be in a hurry to begin a plan of treatment. Almost the only symptoms that call for immediate treatment are hæmorrhage, dyspnœa and pain. Settle your advice as to keeping the bed or the house, as to exercise, rest, food and drink before you give medicine. In prescribing give one drug (with any necessary adjuvant or corrigent) at a time, and in that you obtain the effect you intend. Begin with small doses and increase them gradually to large ones. Make your treatment pleasant, and do not insist on trifles, but be firm on essentials. Try to put yourself in your patient's place.

A Lecture on the Electrophysiology of Nerve and Muscle.

Delivered by DR. STARLING.

I PROPOSE to-day to deal with the nature of electrical phenomena in nerve, and especially with the electrical changes which accompany the excitation of a nerve and the propagation of a nerve impulse.

When it was discovered that electricity could be conducted from one point to another, all thinking men were naturally tempted to draw an analogy between electrical conduction and the propagation of an impulse in a nerve, and to regard this propagation as of an electrical nature.

In 1743 Howsen first put forward this theory, ascribing the propagation of a nerve impulse to electrical conduction. Howsen was, however, essentially a physicist, and did not consider the many physiological difficulties which would have to be overcome before such a theory could be adopted. Haller, a contemporary physiologist, was not long in raising objections. He pointed out, amongst other things, that the nerves were not provided with any insulating sheath, and that the propagation of the impulse was stopped by tying a moist thread tightly round the nerve, a proceeding which would not interfere with its electrical conductivity.

The first definite electrical theory of the propagation of nerve impulses was elaborated by Du Bois Reymond. Up to that time, with the exception of Galvani's doubtful experiment, no one had been able to demonstrate the presence of electrical currents in nerve and muscle. Du Bois (1843) showed that there existed a resting current in nerve and muscle, and that impulses transmitted down the nerve were accompanied by a negative variation of that current.

A theory was then propounded by Du Bois Reymond to account for these phenomena. According to this theory, known as the molecular theory, he supposes that a nerve or muscle consists of molecules charged electropositively at the equator and electronegatively at their two ends. These become arranged in regular succession, and currents set up by excitation of the nerve or muscle are due to a change in the arrangement of these electromotive molecules. Du Bois Reymond was, however, unable to explain exactly what these changes were, nor could he define what electrical changes in the molecules led to the propagation of a nerve impulse.

Pflüger (1859) adopted and elaborated the theory of Du Bois Reymond. He discovered that when a nerve was stimulated at the further end from the muscle the excitation was greater, other things being equal, than when stimulated closer to the muscle; that, in fact, the

impulse set up by stimulation increased in intensity during its passage down the nerve. Pflüger endeavoured to explain this phenomenon by the so-called "avalanche theory," by which he supposed that each electromotive molecule had a residing force which was discharged by excitation from the preceding molecule. In this way the propagation of an impulse was accompanied by continual discharges of energy. Hermann (1867) compared this continuous discharge of energy in the passage of an impulse to a train of gunpowder, which, when ignited at one end, produces an evolution of energy along the whole line. Hermann carried out a long series of researches—one of the most thorough and far-reaching researches in the history of physiology—on the electrical conditions attending the excitation of nerve and muscle, and the propagation of a nerve impulse. He showed that Du Bois Reymond's "resting current" was a "current of injury" or "demarcation current," due to the development of negativity at the injured part. He held that a resting uninjured muscle or nerve is electrically "currentless," and that a current is only set up when any part is rendered negative and therefore at a different potential to the rest, either by injury or stimulation. In this way he brings Du Bois Reymond's "current of rest" and "negative variation" under the same category and explains the latter as a negative polarisation or "current of action," which always accompanies the propagation of an impulse down a nerve. According to Hermann, this negative polarisation is in all probability the means of propagation of the impulse. He supposes that stimulation at any point of a nerve sets up a negative polarisation at that point, by which a current is produced between this point and the adjacent part of the nerve. This current, set up by a difference of potential between the excited part and the adjacent unexcited part is the means of excitation to the adjacent unexcited part, and in this way the impulse is transmitted from point to point down the nerve.

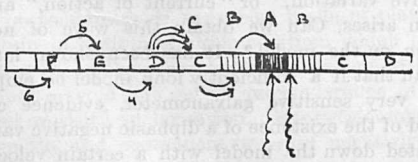


Diagram I.

Thus, in the diagram, the point A is excited and becomes relatively negative to the adjacent point B. A current is thus set up in the nerve from A to B, leaving the nerve at B. B is therefore the cathode of this current and is excited, and becomes in its turn negative. A current is thus set up from B to the point C, which in like manner is excited, and so the electrical disturbance and concomitant excitation are transmitted from one molecule to another along the nerve in either direction.

Hermann showed that the electrotonic changes accompanying stimulation of a nerve can be imitated on a model consisting of a conducting core and a surrounding sheath composed of a dissimilar electrolyte—this had already been done by Matteuci in 1850. Researches on these lines have been further extended by Boruttau, and as a result of these he has been led to the conclusion that all phenomena exhibited by a nerve are purely electrical, and that there is no function in a nerve apart from the electrical.

Our subject to-day is a comparison of these electrical phenomena exhibited by such a model with those displayed by a nerve. The following is a summary of the phenomena which we have to examine with the model, and which we may expect to obtain, if we are to explain them on a physical hypothesis:—

Demarcation current.
Action current (negative variation).
Make excitation at cathode.
Break excitation at anode.
Electrotonic changes in irritability.
Electrotonic current; polarisation, positive and negative.
Polarisation decrement and increment.

If we are able to evolve all these phenomena from the model, we shall then be in a position to refer the occurrence of these phenomena in nerve to the physical structure, rather than to any physiological function of the nerve.

This model consists of a core of some metal, such as platinum, surrounded by a sheath of a solution of some substance, as common salt, which will polarise with the core. Now polarisation is the result of a process of electrolysis, and the model may therefore be compared to an electrolytic cell, in which the exciting current tends to produce by the electrolytic action set up in the cell, a current in the opposite direction. In the model the electrolytic action, and therefore polarisation, takes place between the sheath and the core along its whole length.

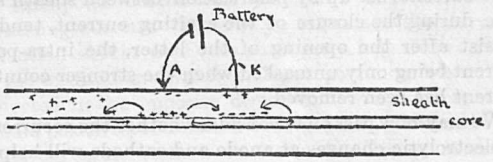


Diagram II.

Diagram II. represents such a model.

At A K a polarising current is thrown in. The current enters at A and in its passage through the electrolytic sheath to the core, it causes liberation of the constituent ions of the electrolyte. Electropositive ions are carried to the core and electro-negative ions are deposited at the sheath and are carried away along the electrode. At this point therefore the layer in contact with the core becomes electro-positive, and a current is set up in the core beyond the anode (in the extrapolar region) in the same direction as the polarising current, that is towards the anode, as shown in the diagram. At the cathode K the core becomes negatively polarised, and a current is set up in the core away from the cathode, that is, also in the same direction as the polarising current. In the intrapolar region a current is set up in the core in the opposite

direction to the polarising current as in diagram, and therefore diminishes the primary strength of the polarising current. These results are more easily seen to conform to the ordinary behaviour of an electrolytic cell, if we imagine the core bent up and dipping into the electrolyte at the two poles.

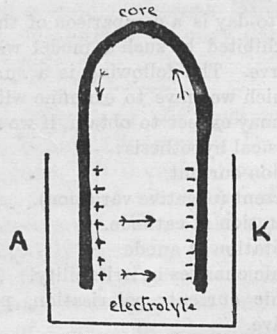


Diagram III.

At the anode A the core is coated with electro-positive ions, and at K with electro-negative ions. It is evident that in this case the liberated ions will cause a current to flow through the electrolyte from A to K, and through the core from K to A, *i.e.*, in a direction opposed to that of the polarising current.

When the polarising current is broken, the polarisation effects remain and give rise to currents in the intra-polar and extra-polar regions, identical with those obtainable in a nerve, and they are exactly what we might expect if we pursue the line of argument already adhered to. In the extra-polar regions we get a continued current in the same direction as the original polarising current. In the intra-polar region a current is set up or now becomes evident in the opposite direction. That is, these electrolytic currents set up by polarisation between sheath and core during the closure of the exciting current, tend to persist after the opening of the latter, the intra-polar current being only unmasked when the stronger counter-current has been removed.

We may now pass on to consider whether the occurrence of electrolytic changes at anode and cathode will help us to explain the fact that on stimulating a nerve or muscle with a constant current, make-excitation occurs at the cathode, and break-excitation at the anode.

When a muscle is made to contract, oxidation takes place in the so-called "inogen" molecules with the production of carbon dioxide, sarcolactic acid and other decomposition products. We may therefore (with Bernstein) suppose muscle and nerve to consist of oxidisable molecules (inogen) which are attached by oxygen molecules, and have side-chains of oxidisable or carbon molecules. The oxidising electronegative ions are liberated at the cathode of the exciting current, which therefore becomes the centre of oxidation. The oxidative disintegration is the excitatory change, and this change is propagated, as already described, as an electrolytic wave from one point of the tissue along the whole structure. On opening the exciting current, the intrapolar polarisation current comes into effect, and this, as already shown, is in the opposite direction. This polarisation current leaves the nerve or muscle at the former anode, which therefore becomes the cathode of the polarisation current, and is excited by this current. If a sufficiently strong current be used, and be closed for a very short time, on breaking the current a positive polarisation current is set up, that is in the same direction as the exciting current. This current is due solely to changes occurring at the anode, and is associated with excitation at this point. Thus in the diagram, IV.

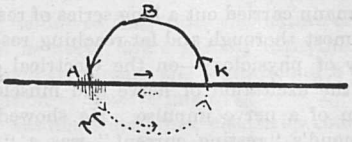


Diagram IV.

a current is led through the nerve from A to K. As soon as this is broken a current due to polarisation makes its appearance, opposed in direction to the battery current, *i.e.*, leaving the nerve at A. If this current is sufficiently strong, it excites the nerve at A. Now an excited portion of nerve is negative to all other portions. There is therefore a current of action set up in the outer circuit from K to A, *i.e.*, in the same direction as the polarising current. This is "positive polarisation." It is evident that the currents obtained from a nerve after the passage of a constant current will be summated from these two effects—the ordinary polarisation occurring at anode and cathode, and the current of action due to excitation at the anode.

On physical grounds, therefore, we can arrive at what is happening when a nerve is excited. We can understand the production of polarisation currents and of electrotonic currents. There is one difficulty, however, which prevented Hermann from accepting the conclusions to which his researches led him, namely, the "negative variation," or "current of action," and the question arises, Can we obtain this wave of negative variation on the model? It has been shown lately by Boruttau that if a sufficiently long model be employed, with a very sensitive galvanometer, evidence can be obtained of the existence of a diphasic negative variation propagated down the model with a certain velocity, as the result of a momentary electrical stimulus applied at one end. This wave of negativity appears to result from a difference in the time-relations of the catelectrotonic and anelectrotonic currents. By means of the differential rheotome he was able to show, that as in nerve so with the model, the extrapolar current at the cathode of a constant current developes rapidly and then gradually diminishes, whereas the extrapolar current at the anode reaches its maximum more slowly, and then falls somewhat rapidly.

The time of appearance of these currents after the excitation, increases with increase of distance between the leading-off and exciting electrodes, but the catelectrotonic current always developes earlier than the

anelectrotonic current, and has a greater velocity. Moreover, if the difference be sufficiently great the anelectrotonic current disappears altogether, whereas the catelectrotonic current may still be present. Boruttau constructed a model in which he could place the leading-off electrodes at four metres distance from the exciting electrodes, and he then in some cases obtained only a catelectrotonic deflection, whatever the direction of the polarising current. If now, instead of a constant current, one excites with an interrupted induction current, the extrapolar regions are alternately anodic and cathodic, and if these effects were in all respects the same, there would be no wave of negativity or positivity, but since the catelectrotonic current developes first, reaches its maximum very rapidly and has at the same time a greater velocity than the anelectrotonic, the latter is completely neutralised, and we have permanent negative polarisation (negative variation) on leading-off two points, one at the end, and the other on the surface of the model. A single induction shock gives rise to a wave of negative polarisation travelling down the model, and thus producing a diphasic variation between any two leading-off points situated some distance from the excited spot. Boruttau has calculated the velocity of propagation of this wave in the model. He finds it to vary with the temperature as in nerve, the average velocity being about ninety metres per second.

It has now to be considered what is the cause of this difference between the polarisation currents at the anode and cathode. Hoorweg explains this difference by a preponderance of polarisation by the oxygen ions over that by the hydrogen. This difference depends upon the nature of the electrolytes. The polarisation currents are supposed to be due to a diffusion of the electropositive and electronegative ions. This diffusion varies according to the nature of the core and electrolytic fluid, that is the occlusive capacity of the metallic core for oxygen or hydrogen molecules, the solubility of either gas in the solution, etc. Thus, Boruttau has shown that catelectrotonus preponderates in the model made of platinum or palladium in sodium chloride solution, which is therefore identical in this respect with nerve, but with a core of copper or gold one gets a preponderance of anelectrotonus or positive polarisation. Hoorweg compares this polarisation and consequent wave of negativity to the self-induction which takes place in submarine cables. One has only to substitute for the condensing action of the gutta-percha covering, the polarising action of the ions, for the loss of imperfect insulation, the occlusion of the gases in platinum and the distribution of these in the solution, and one can then apply the same formula for the behaviour of the polarisation current in the model, as was worked out by Lord Kelvin and Stokes in 1856 for cables. In all respects the cases appear analogous, if not identical. When a current is sent into a cable, and then broken, an electric wave developes after an appreciable length of time, gradually rises to a maximum and then falls again, and it passes down the cable with a definite velocity. Hoorweg further points out that Lord Kelvin's formula for the strength of the self-induced current in the cable corresponds exactly with that worked out by Weber from Hermann's theory for electrotonic currents in nerve. This negativity, *i.e.*, the preponderance of catelectrotonus or negative polarisation over anelectrotonus or positive polarisation is, so to speak, merely an accident, depending, as it does, upon the nature of the electrolytes in the model, and it is by no means invariably present in the tissues. It exists only slightly in muscle and is not found at all in non-medullated nerve fibres*, but this in no way militates against its physical nature as dependent upon the structure of nerve and muscle. We thus see that the most essential electrical phenomena in nerve and muscle can be obtained in our model and can therefore be explained on purely physical principles.

We have now only two points left for consideration, namely, polarisation decrement and increment. These phenomena we shall find easily explainable if we bear in mind exactly what, by our investigations with the model, we know to take place with a nerve on excitation. Suppose we pass a constant current through a nerve at a and k, and we lead off to a galvanometer at c and d, we shall get a deflection of the galvanometer indicating

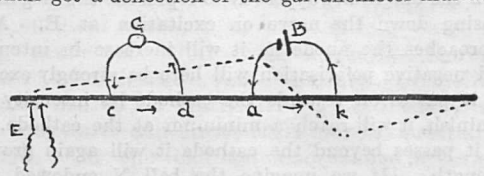


Diagram V.

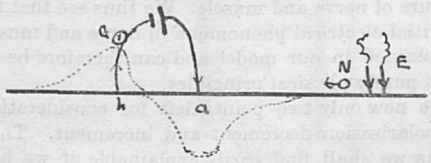
an extrapolar current in the same direction as the polarising current. If now we stimulate the nerve by induction shocks at E, we shall get a negative variation of the extrapolar current and the galvanometer will be deflected in the opposite direction. We have at a the anodic positive polarisation taking place, whereas at any point c remote from a we have negative polarisation. Now the excitation sets up a wave of negativity, and this will increase in intensity as it passes over a point of positive polarisation, and will diminish in passing over a negative region. A negative wave may be regarded as a tendency to set free electronegative ions. It is a wave of disintegration. This disintegration will take place with greater intensity at the anode where the opposite polarisation is taking place, and where, therefore, there is a ready supply of electropositive ions, than at the cathode where disintegration has already taken place.

This wave of negativity, then, propagated by excitation at E, will cause a greater negativity or electropositive disintegration at D than at C, and this negative polarisation at D will tend to set up a current from D to C in the nerve, that is, in the opposite direction to the

* In non-medullated fibres, so far as has been investigated, only anelectrotonic currents have been found.

extrapolar anodic current. We thus get polarisation *decrement*. The same decrement of the cathodic extrapolar current may be shown. Negative polarisation is excited by the wave of negativity to a greater extent at a distant point than at a point nearer the cathode, and, therefore, a current is set up towards the cathode, in the opposite direction to the cathodic extrapolar current.

If we now study the effect of the exciting current upon the polarising current itself, we find that the wave of negativity tends to set up a current in the same direction, and so cause an *increment* of the polarising current. This can be explained by the same reasoning.



Dotted line = negative polarisation of nerve.
Gimaginary path of N.

Diagram VI.

In the diagram, suppose N to represent the negativity passing down the nerve on excitation at E. As it approaches the anode, a, it will increase in intensity. and negative polarisation will here be strongly excited. As it passes on towards the cathode its intensity will diminish, it will reach a minimum at the cathode, and as it passes beyond the cathode it will again grow in strength. (If we imagine the ball N endowed with inertia, it is evident that it will attain its greatest velocity at a and its least velocity at k, the top of the curve of negative polarisation.) From this it is evident that a current will be set up in the nerve from a to k, that is, in the same direction as the polarising current.

All these phenomena have been reproduced on the model, as one would expect. Assuming, then, that nerve is constructed on some principle such as we find in the model, we are able to explain all the phenomena of excitation and propagation of a nerve impulse, and we have only left to consider the changes which take place at the end plates by which these polarisation currents are enabled to excite contraction of the muscle. A comparison of the end plates with the electrical organs has suggested the possibility that the excitant of the muscles is really an electric shock generated in the end-plates, but there are at present many difficulties to be overcome before we can accept this as a likely explanation. [Reported by L. E. Stamm.]

Chapel News.

The collections on Christmas Day were for the Institution Maternity Fund, and amounted to £5 9s. 10d.

Services in Preparation for Holy Communion:—Saturday, January 7th, 10 a.m. and 9.50 p.m.; Saturday, January 21st, 10 a.m. and 9.50 p.m.

Testimonial to Dr. Parry-Jones at Alfreton.

DURING the past week a number of Dr. Parry-Jones' friends have shown their appreciation of his ability and kindness by forwarding to his new residence at Derby a number of valuable presents. The testimonial included a roll-top writing table with handsome revolving chair, a comfortable lounge chair, with reading easel attached, a silver salver, and two pairs of silver candlesticks, the silver being engraved with the monogram of the recipient. No public appeal was made, but the spirit in which donations were sent testified to the popularity of Dr. Parry-Jones among all classes. The presents were accompanied by a framed illuminated address, which was beautifully executed. Previous to leaving Alfreton, Dr. Parry-Jones had also received a beautiful writing case with brass inkstand and candlestick from a large number of his Alfreton patients. A handsome standard lamp was presented to Mrs. Parry-Jones from the Trained Nurse Committee, in recognition of the invaluable work done by her as hon. secretary, in founding and carrying on the work.

Nursing News.

On January 2nd, Miss Grundy (Sister Beardoe) took up the duties of Sister in the Surgery, and Sister Catharine went for a short holiday before commencing her work in Patience Ward.

On January 4th, Nurse Heath left the hospital to join the Institution, and Pro. K. Taylor went to Stephen as head nurse.

On December 21st and 22nd the new building in the park was ready for occupation, and forty-eight probationers and the Assistant Matron moved in. The building is admirably adapted to the temporary residence of the nurses, who have gained much by their change of residence.

Nursing Examination, December 22nd, 1898. List of Successful Candidates. — Allen, G., Allcock, Adams, Archdale, Baker, B., Beales, Beard, Bennett, Bible, Blayney, Blower, Collins, B., Collins, L., Clark, Cooper, Copley, Crampton, Creasey, Daniels, B., Davidson, Davison, Denyer, Drever, Ellis, Faulkner, Field, Gale, Galway, Gatward, Gibbins, Gibson, Goodwyn, Graham, E., Green, Harbottle, Harradine, Hayward, Hembling, Heygate, Hickman, Hindley, Hobbs, Holman, Houstoun, Hughes, Hyde, Johnson, Lamb, Leveaux, D., Leveaux, V., Lewis, Lord, Lowthin, Lyon, Mallandaine, Mackenzie, Mombert, Moore, Mousell, Mudge, Nash, Norwell, Oldham, Overbury, Palmer, Park, Parlby, Pitman, Porter, Rainbow, Ramsey, Reeve, H., Rickwood, Roberts, Scholfield, Smart, Smith, Spedding, Stanyon, Studdert, Swadling, Tompkins, Wallis, Warren, A., White, Whiteman, Wood, I., Wood, V.

Passim.

Now that Christmas has come and gone, and looking back upon the whole week, we are quite justified in saying that we have never spent a more enjoyable time at the hospital. From first to last things went with more spirit and go than usual, and there was a noticeable air of general good humour about. The concerts were above the average, and the only fault we have to find with them is that not much new hospital talent was forthcoming, and the whole burden of entertainment rested upon two or three hard-worked popular favourites, who have been rushed from one concert to another to the point of exhaustion.

THERE surely must be some singers or comedians among the men who have not yet entered the wards, or else there is a dull time in store for the hospital in the near future. The dearth of talent may be explained by the fact that there was no smoking concert before Christmas this year, and new men have had no chance of showing what they can do. We sincerely hope it is so.

THE Out-patients' tea to 500 poor children on Boxing Day was a great success, and Mr. Landon and his helpers are to be heartily congratulated on their labours. The children had an exceedingly good time and thoroughly enjoyed themselves, and finally went away laden with good things within and without. A few of them turned up to the Front Surgery the next morning with the usual gastritis, but the cause was apparently a surfeit of material rather than any poisonous ingredients in the food provided by Mr. Landon.

To sum up the rest of the week. There was the patients' dinner on Boxing Day, also about fifteen ward concerts, and impromptu sing-songs in the wards in the evenings, and three days' hard work decorating for a couple of hundred men. All these things with an effort to make Christmas in hospital somewhat of a merry one for those patients who could not be at home. The public recognition of all this, some five lines in the papers. And the next time that a coroner's jury adds an ignorant rider to a verdict, the same newspapers will blossom out into catchpenny columns of fatuous comment. To these knights of the pen a good headline is preferable to the recognition of a good deed done in quiet.

THERE has been much wild rumour in the last fortnight that this is the last year in which decorations are to be allowed in the wards. On inquiry, this report is found to be totally inaccurate. Amateur decorators have a pretty way of driving promiscuous nails of large size into plaster walls with great effect, and orders were given that none such nails were to be driven into the walls of Queen Victoria ward; hence the rumour. As a matter of fact, arrangements are being made in the Surgical Wards, as each is done up, to fix hooks in all the walls at intervals for the attachment of wires in future years.

THE hand of the builder is exceedingly busy about the hospital these days. Dorcas is being rapidly pushed forward for the reception of more surgical cases, a new asceptic theatre is being made of what was formerly Dorcas private room, and very shortly Cornelius patients are to be transferred to old Mary, so that the ward can in its turn be re-floored and cleaned. In the College also there is much activity. What with new rooms for the two Obstetric Residents and a new bath for the Warden, there is no peace in the quadrangle, especially in the morning, when honest men want to sleep.

A CORRESPONDENT has sent us the following elegant mixture prescribed for an apparently healthy seaman in the neighbourhood of the London Docks:—

℞. Bicarbonate of Soda	...	ʒi.
Liquid Bismuth	...	ʒii.
Laudanum	...	ʒss.
Sp. Camphor	...	ʒi.
Tr. Capsici	...	ʒi.
Tr. Rhei	...	ʒi.
Sp. Chloroformi	...	ʒi.
Tr. Zingiberis	...	ʒi.
Essence of Peppermint	...	ʒi.
Syrup. Simplex	...	ʒii.
Tr. Catechu	...	ʒi.
Aq.	...	ʒvi.
		ʒi. 4tis horis.

Strange to say, the patient said it did him no good. Some one of the ingredients ought to have touched the evil.

A FABLE

(Adapted with apologies from R. L. Stevenson).

"THE STUDENT AND THE TRAVELLER."

"Look around you," said the student. "This is the largest hospital in the world."

"Oh, surely not," said the traveller.

"Well, perhaps not the largest," said the student, "but much the best."

"You are certainly wrong there," said the traveller. "I can tell you . . . ."

They buried the stranger at the dusk.

MORAL.—There are other hospitals.

THERE were comparatively few men to celebrate New Year's Eve round Guy's statue this year, most probably owing to the shocking weather, the ground being wet through and rain falling heavily all the evening. The usual crowd assembled outside the gates and appeared to enjoy the fun, and the windows round the quadrangle were mostly occupied with interested spectators. Next year ought to see a large crowd assembled to welcome in the new century.

MOST probably by the time this GAZETTE is published, the long-looked-for Reports will be issued, as they are now all printed and ready to distribute. The volume is slightly larger than the last, and judging from a hasty glance, appears to be quite up to the usual high standard of interest.

WE would remind all men that it is their duty to contribute to the general fund for Christmas tips to Hospital College and Club servants, among whom it is divided equally. A large amount of money is saved to them by the absence of all gratuities, and five shillings is a small enough sum for all the services rendered in the year.

THE Title-page and Index to Volume XII. for 1898 is in the hands of the printer, and will be ready in a few days, when a copy will be sent to all those who may intimate their wish to have one. Subscribers desirous of having their sets of the GAZETTE bound, should send them as soon as possible, with 1s. 6d. per volume, to the Librarian. The binding is in blue and gold—navy blue, or the lighter shade hitherto used.

MESSRS. ASH have devised an appropriate case, in a shade of maroon and gold, for the *Guyoscope*. Sets for binding and 1s. 6d. per volume should be sent to Mr. Pamment, at the Medical School Office.

Pass List.

University of Oxford.

EXAMINATION FOR THE DEGREES OF M.B., B.CH.

F. E. Fremantle, R. O. Moon.

University of Cambridge.

THIRD EXAMINATION FOR MEDICAL AND SURGICAL DEGREES.

PART I.—A. C. Fry, H. A. Gaitskell, F. A. Godson, F. J. Nicholls, F. Shufflebotham.

PART II.—S. E. Denyer, F. J. Lidderdale, W. K. Wills.

SECOND EXAMINATION.

PART I.—A. G. Harvey.

PART II.—J. A. Andrews, E. Bigg, F. Richmond.

University of London.

M.S. EXAMINATION, DECEMBER, 1898.—C. H. Fagge.

M.D. EXAMINATION, DECEMBER, 1898.—A. P. Allan, W. H. Jewell, E. Ivens Spriggs.

M.B. EXAMINATION, OCTOBER, 1898.

HONOURS.

MEDICINE.—FIRST CLASS.—R. H. J. Swan.

OBSTETRIC MEDICINE.—THIRD CLASS.—V. E. Collins, D. J. Munro, A. G. G. Plumley.

FORENSIC MEDICINE.—FIRST CLASS.—V. E. Collins.

B.S. EXAMINATION, DECEMBER, 1898.

HONOURS.

SURGERY.—SECOND CLASS.—D. J. Munro.

PASS EXAMINATION.

FIRST DIVISION.—D. J. Munro.

SECOND DIVISION.—H. W. Bruce, E. Coleman, L. E. C. Handson, R. H. J. Swan, W. H. M. Telling.

Appointments.

CIVIL.

CULMER, JOHN J., M.R.C.S., L.R.C.P. Lond., has been appointed an Assistant Surgeon for the New Providence Asylum at Nassau, Bahamas.

NAVAL AND MILITARY.

SURGEON SIDNEY CRONEEN, R.N., has been appointed to the *Victory*.

MAJOR R. E. R. MORSE and CAPTAIN G. L. RAWNSLEY, R.A.M.C., have been detailed for service in India.

Christmas Week.

CHRISTMAS DAY falling on Sunday this year, all festivities, including the Patients' Dinner, were postponed till Boxing Day, on which date, as usual, the Christmas dinner of roast beef and plum pudding to the patients was provided by the Staff and students, and smoking was allowed in all the men's wards, in this case also the material being provided by the students.

THE WARD DECORATIONS.

Considered as a whole, the decorations this year were more successful than on former occasions, holly and evergreens being good and plentiful; and the scheme of decoration was generally lighter and more effective than usual, too much heavy festooning being avoided. The most successful attempt was achieved in Dr. Pitt's division of STEPHEN, which looked by far the best of any ward, chiefly owing to the lightness and care with which the festoons of ground ivy had been arranged. But for a complete review of the ward decorations it is necessary to begin at the beginning and work through the wards *seriatim* to the bitter end, as promiscuous notice might possibly lead to neglect of some ward, with resulting disasters to the good repute of the report. To commence, then, on the ground floor:—

In ASTLEY COOPER the feature which first struck the eye was a screen of ivy arranged as a lattice work just inside the door, with three pendant baskets of yew and holly sprays. The two fireplaces were draped with red and white cloth from the ceiling to the mantelpiece, the two latter being decorated with batteries of obliquely-placed ferns concealed in moss. At the concert, two tea tables lighted by candles with red shades and decorated by baskets of red tulips were particularly effective. A crushed strawberry pink cake on one of these was a conspicuous spot of colour.

ASTLEY COOPER.—CHRISTMAS, 1898.

CORNELIUS looked exceedingly well, the evergreens being particularly well arranged, a spider's web of ivy on the ceiling being a triumph of design. Over the door were the initials of the two surgeons who have beds in the ward.

LYDIA was decorated in the military manner, the mantelpieces supporting large trophies of Lee-Metford rifles and ugly-looking swords and spears—we suppose from Omdurman. Holly and ivy everywhere, as everywhere else.

MARTHA mantelpiece was illumined by a large anagrammatical poem of Christmas welcome by some hospital poet, the initial letters of the lines read vertically spelling the name of Mr. Golding-Bird. More holly and ivy in festoons.

In JOB there was, as in ASTLEY COOPER, a lattice-work screen just inside the door, with "Salve" and "Cave Canem," etc., worked in holly-leaves— a quaint conceit. The ubiquitous festoons were exceedingly well done; the lanterns were as effective and as well hung as anywhere.

In LAZARUS the festoons were hung right across the ward instead of lengthwise or obliquely, but they were hung judiciously high enough, so as not to spoil the perspective of the ward. We could have given a longer notice of the decorations of LAZARUS if an enormous crowd had not rendered the ward impassable on the concert night.

The artistic value of red as a colouring for decoration was very well shown in LUKE; all the electric lights had red shades, and the contrast of these with the green holly and ivy was particularly effective.

In CHARITY the trend of opinion was in favour of Chinese lanterns rather than evergreens, and, as the ward is rather a low, long one, the lightness of the decoration was, on the whole, to be commended.

It was quite a relief after such a profusion of festoons to come into NAAMAN and see none. The flat, geometrical designs in ivy upon the ceiling were exceedingly good, and the plain outlining of the windows in green was much more suitable than any other form of design.

SAMARITAN, on the other hand, with its angle roof and cross bars, gives a good field for the unconventional method of decoration in the shape of festoons. The men who work in this ward are nearly always of necessity successful in their efforts at Christmas from the immense architectural possibilities of the top storey.

In CLINICAL, again, owing to the greater architectural attractions of the building, the Clinicals had wisely contented themselves with accentuating the normal lines of the wards with ivy, with great success.

The EYE WARDS looked very well with heavy festoons of yew and holly, as the ward is sufficiently high to carry a weighty scheme of decoration. Over the mantelpiece was a trophy in the shape of the Guy's crest with a background of drapery in the hospital colours.

OUT-PATIENTS was very well done this year, being adorned with long lines of holly, ivy garlands, and trophies of flags. The gas brackets were artistically decorated with vivid artificial holly, and Mr. Landon achieved a triumph of invention in the shape of a tinsel bird-cage arrangement, pendant from the ceiling, the cynosure of all eyes. Sister's room looked most inviting, with a red baize carpet and tasteful wall decorations.

MARY is a colossal task for decorators, the size of the ward being enough to frighten most men in their attempts to achieve a success. The men this year are to be heartily congratulated on their efforts, the effect of the light ivy sprays being most pleasing.

PHILIP was most carefully and artistically done, the ivy and holly festoons being hung sufficiently high so as not to spoil the view, and the brown polished floor making the ward look much more cosy and Christmas-like.

STEPHEN, as we have said above, was the most successful of all the wards this year. Some lines of ivy hung like curtains over the door were an unqualified success. The festooning was very lightly done, and well designed, and a spider's web in fine ivy in one of the openings was exceedingly good.

THE NIGGERS ON BOXING DAY.

There being no public performances of the Niggers this year, the Christmas Entertainment in the Wards was more or less of a scratch affair, but it was none the less successful for that, the general opinion being that the show was one of the best of recent years. The troupe was comparatively a large one, and comedians were well represented, and music was supplied by a phunnyphone band. The artistes were: A. J. Cleveland, interlocutor; Spon, Miller, Fitz-Hugh, Cazenove, Wacher, Brockwell and Collins, cornermen; Atkins, Parrot, Ransford and Starling, sentimentalists; and East, Brickdale, Evans, Hodgson and Porter, performers on the phunnyphones, accompanied by L. E. Stamm on the guitar.

The tour commenced as usual at one o'clock in Barnabas, and eventually ended up in Astley Cooper at seven o'clock, everyone being by then dead beat. The shows went with much more spirit than usual in the Medical wards, partly owing to the great division of labour among the cornermen, each man having good time to prepare his scintillating jest. The most successful items were sung by Wacher and Cazenove, both of whose canticles have since become popular songs of the day with the patients in the last week. Cleveland made an excellent interlocutor, and had a most striking make-up, a shaving brush beard adding greatly to his personal attraction. Miller's scarlet silk bodice fastening behind, with check *dessous* and sash was a triumph of dress design. The other dresses were all well thought out and effective, but do not require individual mention. The reception given to the Niggers in Out-Patients was literally deafening, and the way the children caught on to Spon's wheeze and nearly spoilt his joke by repeating it, was most amusing. As usual, owing to the kindness of the Nursing Staff, some eight teas were successfully achieved in the course of the afternoon, but with no harm to any of the artistes. The round finished with a most excellent performance in Astley Cooper, the best show of the day.

In the evening the Niggers were entertained to dinner by the Residents, and subsequently proceedings were of the most orderly description.

STEPHEN CONCERT.

Friday, December 30th.—4–6 p.m.

On the whole a most excellent concert—that is, the music was good, but not too good, and the popular

element was well to the fore. Owing to late arrivals there was some lack of spirit at first, but after the interval everything went with a swing. One real star appeared in the form of Miss Jerrard, of the Savoy Theatre, who sang in charming style two old friends, "Cherry Ripe" and "The Miller and the Maid," and in a song by Miss Aylward, "Beloved, it is Morn," the audience rose to the occasion. An almost-real star, although an amateur, appeared in the not too common guise of a conjurer; Mr. Powell's performance of some perhaps old tricks in a new form, accompanied by a quietly humorous explanation, completly upset the audience, especially some patients in the front row. At the back we were unable to hear his remarks, so we talked instead ourselves. It was quite like old times to see Mr. Lidderdale enjoying himself during the first fourteen items, and then to hear him in this item discoursing Grieg and Wagner with the soft pedal down so as not to drown the conjuror's voice too much. Mr. Wimperis sang two comic songs in a certain amount of dialect with striking effect, especially in the last; but that gag of pretending to forget the words may be overdone: three times in one verse is really too much, even if it is the last. Mr. Cazenove gave his own, a really excellent composition, "Sing me a Drawing-room Song," with his usual spirit, making one wish that all drawing-room and comic songs were equally spirited. The great point of this great work is that the audience do not realise that they have got to laugh until the end of the second verse: until then their faces are a study. Mr. Hobbs has a very fine baritone voice, and sang "Father O'Flyn" really well, while with Mr. Murray Graham he sang "Excelsior," a most creditable performance seeing that it was wholly impromptu, and had not been sung by one of the performers for ten years. Mr. Graham sang two other songs of love. Miss Hicks has a very pleasing voice, almost as pleasing as her brother's, and that is saying a great deal. The Misses McGavin also sang and played the mandolin and guitar, in which we felt additional interest apart from the liveliness of their performance. Mr. Parrott's voice is always pleasant, and has developed considerably since its first introduction to the hospital.

NAAMAN.—CHRISTMAS, 1898.

Mr. A. T. Winter played and accompanied with commendable energy, the nursing-staff and clerks distributed refreshments with untiring zeal, Sister and the H.P. were as hospitable as possible, and the whole thing was a great success. Among those present we noticed Sam

and, above all, Willie, who supplied more entertainment than any of the other performers.

PHILIP CONCERT.

Ward concerts are variable in attraction, the success of the evening depending upon such a multitude of circumstances, the time, the day, the temper of the audience, and so forth. Philip concert was undoubtedly one of the best we have heard in the last two years. The ward looked well, the place was full, and there was a good programme, and no more was needed. Mrs. Kendal was superb, we could have listened for a whole evening to her fascinating reading. The greatest tribute she could gain she won, to wit, the appreciation of the patients, a portion of the audience often neglected in ward concerts. Miss Mason played some really excellent violin solos, and Mrs. Lane Clarke sang exceedingly well. Cazenove never sang better in his life than in "Sing me a drawing-room song," the music of which is the invention of his own fertile brain. The rest of the programme included piano solos by Mr. Carruthers, songs by Mr. Arthur Miller and Starling, and recitations by Miss Tripp. Mr. East is to be heartily congratulated on a most successful evening's entertainment.

EYE WARDS.

On Wednesday evening, December 28th, the patients in the Eye wards were given a performance of Mrs. Jarley's Waxworks, through the kindness of Mrs. Leaf, who brought a party of friends with her to form the waxwork collection. A stage was erected at one end of the hall in Ruth, with footlights and curtain, while Barnabas was reserved for the performers. A most excellent entertainment was given, Mrs. Leaf being a most spirited Mrs. Jarley, and the whole troupe acting their respective parts with much "go" and humour. The two comic stage carpenters were excellent. At the conclusion of the performance Mr. G. B. Smith, in a graceful little speech, expressed the sincere thanks of the audience for the kindness of Mrs. Leaf and her friends in coming down to Guy's and giving such amusement to the patients. The evening terminated with "God Save the Queen," and tea to the visitors.

LAZARUS WARD CONCERT.

This concert held on Friday, December 30th, was very successful. The ward, which looked extremely pretty, was well filled throughout by an appreciative audience. Before the interval Miss Purnucott and Miss Secretan sang well "Stars the Night Adorning" and the "Miller and the Maid" respectively, whilst "La Serenata" was finely given by Miss Barker. The comic element was upheld by Mr. Bush and Mr. Brockwell, the latter receiving an encore; and a string quartette of ladies played extremely well a pretty gavotte "Immer Wieder," which was also encored. We think, however, that Part I. of the programme was slightly marred at one point by a somewhat ill-chosen item. In Part II. in addition to most of the above-mentioned performers who appeared again, Miss Swan and Miss Cregoe gave respectively a song and violin solo, Mr. Atkins was encored in "Tommy's Tournament," and Mr. Miller was very funny in "Selected," and "The Wide, Wide World Man." The quartette also were again much appreciated.

NAAMAN CONCERT.

The last Christmas concert took place in Naaman on the Saturday evening in Christmas week, and was an unqualified success; in many ways it was one of the most pleasurable entertainments of the week, as the patients evidently so thoroughly enjoyed themselves. The Stavordale Banjo Quartette very kindly gave their services, and we have seldom heard such artistic performances. They were most enthusiastically received. Mr. White played exceedingly well on the 'cello, and an old friend in the person of H. T. Hicks appeared at this concert only. With increasing years his voice has lost none of its pristine sweetness. As in Cornelius, Sister Christine sang "Home, Sweet Home," and had the pleasure of receiving a most tremendous reception. If only more people would follow her example and sing old and well-known songs, but sing them *well*, the people for whom the concerts are primarily intended—the patients—would be more deeply touched than by the latest song of Grieg. Miller and Cazenove sang the old favourites to the same clamouring audience, and received their usual rapturous encores. The following ladies and gentlemen also helped:—Miss Dupuis, Mr. Brickdale, Miss Pendrell Smith, Mr. Grieg, Miss Gubbins, Mr. Edwin, Mr. Wacher and Mr. Ormond.

ASTLEY COOPER CONCERT.

On Wednesday evening, December 28th, a most successful concert was given in this ward. The programme was an exceedingly long one, but everyone seemed to enjoy every note of it, and left reluctantly. All the artistes received a very hearty welcome, every item gaining loud applause. Special mention must be made of the Santa Claus Amateur Banjo Troupe of six performers, who most kindly contributed several excellent items, which were much appreciated. Miss Swan sang several songs in a most artistic manner, and the following ladies and gentlemen also contributed their large share to the general success:—Miss Wittick, Miss Clough, Miss Stone, Miss Owen, and Miss Wigan, and Messrs. Atkins, Ben Copeland, Leigh Clare, Fiske, Brockwell and Wacher. At the conclusion of the evening Mr. Clement Lucas, in a few well-chosen words, heartily thanked all those who had so kindly given their services.

CORNELIUS CONCERT.

"Corney" concert is always one of the best and brightest of the Christmas festivities, and this year was no exception to the rule. The final test of the success or failure of a concert is the enjoyment evinced by the patients, and judged by this standard Corney concert must be written down a big success. Among the most

notable items were pianoforte solos by Miss Eason and Mr. Hillary Edwards (who is also a comedian); violin solos by Miss Powell and Miss Borrowdaile; songs by Miss Newton, and the comic efforts of Mr. Wacher. Best of all, to our mind, was Sister Christine, who sang "My old Dutch" and "Home Sweet Home" as they should be sung, and met with an enthusiastic and well-deserved reception. The whole programme was particularly strong and discreet, and the greatest credit is due to the newest Sister Corney and Mr. Booker.

MARTHA WARD CHRISTMAS TREE.

About a hundred children were collected from the various wards of the Hospital to attend this juvenile entertainment. Some of the children, who had formerly been patients, were also invited, although they were not then inmates of the hospital. The ward was very tastefully decorated, the most striking feature being an arch decorated with holly and ivy. Heavy festoons of evergreens passed from bed to bed on each side of the ward, whilst the rest of the ward was adorned with light ivy festoons and Japanese lanterns. The first item on the programme was a conjuring entertainment, which the children thoroughly enjoyed, although they maintained almost absolute silence. They seemed specially amused by the hat trick. After an interval for tea, a Punch and Judy show was given. Everyone, both old and young, seemed to enjoy this, and the children shrieked with laughter. After this, Mr. G. E. Richmond, attired as Father Christmas, proceeded to distribute the toys from the Christmas tree. The toys were well chosen, and the children seemed highly delighted with their presents. Mr. Cosmo Bonsor, the Matron, the Assistant Matron, and Mrs. Perry, and several Sisters of the hospital, were amongst the visitors. Mr. Meachen kindly played one or two solos on the pianoforte during the interval.

QUEEN VICTORIA CONCERT.

Great praise and many thanks are due to Mr. Frank Goldsmith for the pleasure his concert in Queen's gave to a large audience. In spite of the fact that three of the gentlemen billed to appear did not turn up, the concert lasted a full two hours. Part I. was devoted to a humorous duologue by Eden Phillpotts, entitled "A Breezy Morning," which was admirably acted by Miss Alice Robbins and Mr. Frank Goldsmith himself. Both performers worked hard, and richly deserved the applause they received. Part II. was opened by Miss Edith Balls at the piano. Later on in the evening this lady covered herself with glory by her rendering of "Beloved, it is morn," but the beautiful quality of her sweet voice was heard to greatest advantage in "Forget me Not," which she sang as encore to "A Summer Night." Mr. George Lennard favoured us with "Little Tommy Tit-Bit," "My Tyke" and "The Moocher." Mr. Lennard is a born comedian. Mr. Charles Phillips filliped the banjo, seeming to be possessed of twenty fingers, and he played three times to the audience's imperative demand, while Mr. Adrian Clifford showed us "How it's done," and made us quite nervous for safety of his lower jaw while reciting "The Stuttering Whistler."

The stewards, who "stewed" splendidly, were Messrs. V. E. Collins, Porter, Spon and Jephcott. The concert was brought to a close by a vote of thanks by Mr. V. E. Collins to the performers, and a courteous reply from Mr. F. Goldsmith.

SAMARITAN AND PATIENCE CONCERT.

Never within the memory of the writer has Patience looked prettier. Fairy lights and climbing verdure everywhere; and the concert, well, let it be said at once that the concert was a big success. Amongst the songs and vocalists, Mr. Fairholme with "The Bonny Banks of Loch Lomond," Mr. McD. Parrott and his "Deathless Army," and Mr. Atkins' "Simon the Cellarer," gained great credit; and amongst the ladies Miss Grose with "The song that reached my heart" did so, and then sang "The Swanee River" as a deserved encore. Miss Oliver Williams and Miss Coward received great applause for their songs. The instrumentalists were the Misses Hicks, who did wonderful things at the piano; Mr. Levey with the "cello," and Messrs. Constantine and Williams who banjoed together and gained encores.

Comedy was in the able hands of Mr. McCraken whose rendering of a blood-curdling melodrama was immense. Clever Mr. Brockwell sang "Clever Mr. Green," and Mr. Constantine sang "The Doctor" and made the patients feel quite homely. Many thanks are due to Mr. Densham who, besides playing the overture, wrestled with nearly all the accompaniments of a very pleasant evening.

MARY CONCERT.

The concert in Mary ward was held on Wednesday at 4.30 p.m., and was a great success. A varied and elaborate programme was set forth.

Miss B. Starling played a pianoforte solo very well. We remember having heard it before, but cannot recollect the name of the piece. Miss May Collette then sang in her peculiarly piquant style. Later Miss Collette again sang. Of her four songs, "The baby's point of view" and "Darling Joe," both by Leslie, were the best. Mr. Charles Collette then gave a few words on "The humours of advertisement," and sang his inimitable song "A lot to do to-day." The audience seemed immensely pleased with both Mr. and Miss Collette, and encores were demanded and given. Monsieur le Chevalier de Munck then played a "Chansonette" and a "Polonaise," both by himself, on the 'cello. Seldom, if ever, have we heard more exquisite playing or sweeter tones from that instrument. Miss B. Starling accompanied Mons. de Munck with great skill and taste. In the second half of the programme Miss C. Ferguson played a violin solo very sweetly, Mr. Conrad Cooke gave a very good exhibition of his phonograph, and Miss M. Orr sang "May Morning," by Denza, very charmingly. If we remember aright Miss M. Orr sang in the Dorcas concert of last

year, and created a great impression by her excellence of voice and style.

LUKE WARD CONCERT.

An undoubted success was scored by the concert in Luke ward on December 29th. Although the programme was somewhat different from that which was published, owing to the professional duties of some of the artistes, the entertainment went without a hitch from start to finish, and when the National Anthem brought the proceedings to a close, the specified time had only been exceeded by ten minutes. The ward was very prettily decorated in the style one usually associates with surgical wards, and, what is hardly sufficiently insisted upon for concert purposes, there was a good, though subdued, light throughout the ward. Appended is the programme. Pianoforte Solo, Miss Hodgson; Song, The Longshoreman, Mr. McD. Parrott; Song, The Amorous Goldfish, Miss Willey; Comic Song, Irish Patter Song, Mr. W. Hengler; Song, Butterflies, Miss McDonald; Comic Song, The Penny Whistler, Mr. W. Hengler; Song, Miss Willey. Interval. Song, Mr. Cazenove; Song, Husheen, Miss McDonald; Song, Drinking, Mr. D. Bryan; Recitation, Mr. Cairns James (Lyric Theatre); Song, Lesson with a Fan, Miss Willey; Comic Song, Mr. Cazenove; Song, The Bell Buoy, Mr. D. Bryan; Song, Miss Willey. God Save the Queen.

JOB CONCERT.

The concert in Job may be considered quite one of the most successful of the ward concerts of this season. The songs were excellent, the artistes without exception in capital form, and the audience most appreciative. The recitations of Mr. Beck, especially the second, which was from a literary point of view far superior to the first, were much applauded. The comic songs were as usual very well received. Miss Swan sang with taste and finish, and the opening numbers in each part by Miss Eason and Mr. Cazenove were very spirited and inspiriting performances.

The programme was carried out by the following ladies and gentlemen:—Miss Eason, Miss Stamm, Miss Swan, Messrs. Cazenove, Collette, Starling, Beck, Parrott, Miller and Fortescue-Brickdale.

CLINICAL CONCERT.

The Clinical concert on Thursday, December 29th, was an unqualified success. In so excellent a programme it would be invidious to draw distinctions,* but rarely have we heard in a ward concert anything to equal the violin solos of Miss Toms, the naive and delicacy of which completely captivated the audience. Madame Loveneg's rendering of "Spring is coming" and other songs, was also exquisite. Both parts of an all too short programme were brought to an end by the plantation songs of Mr. Alexander's humorous and talented company, who appeared to be blissfully ignorant of the dangers of a ricketty platform, from which we were glad to see them ultimately descend in safety.

Programme:—Pianoforte Duet, Miss Blower and Miss Tupman; Song, The Yeoman's Wedding, Mr. Rogers; Song, All Souls Day, Miss Dupuis; Violin Solo, Miss Amy Toms; Song, The Storm Fiend, Mr. Parrott; Song, Sing me a drawing-room song, Mr. Cazenove; Song, Spring is coming, Madame Loveneg; Plantation Songs, Mr. Alexander's Company; Piano Duet, Miss Blower and Miss Tupman; Song, Miss Dupuis; Violin Solos, Miss Amy Toms; Song, Beauty's Eyes, Mr. Rogers, Song, Madame Loveneg; Song, We 'ad a time, Mr. Cazenove; Song, The Deathless Army, Mr. Parrott; Plantation Songs, Mr. Alexander's Company.

* We cannot hold ourselves responsible for the phrase.—ED.

THE OUT-PATIENT TEA.

The Second Annual Tea, given to the poor children of the neighbourhood, was even a greater success this Christmas than it was in 1897. Well over 500 children sat down to tea at 2 o'clock on the afternoon of December 26th, and the Out-Patient department, in which the whole affair again took place, had undergone a remarkable transformation from the usual dull and dingy condition. The decorations were quite elaborate and very effectual. Flags and evergreens, with ivy wreaths, lanterns and fairy lights, were displayed with a judgment and taste which bore great credit to those who had cheerfully given up many hours of the preceding days to the beautifying of the place. The Matron very kindly allowed any of the night staff of nurses who wished to assist at the tea to do so, and it speaks volumes for the energy and kind-heartedness of our nurses that nearly the whole of the night staff turned up punctually at the appointed hour, and rendered invaluable assistance in the dispensing of the caterer's plain, but wholesome viands, and with the subsequent marshalling of the children for the Punch and Judy and Nigger shows, and the finale of the magnificent Christmas trees. All hands worked with a will, and although noise was a prominent feature of the afternoon, still order was fairly preserved during the whole of the three hours during which the entertainment lasted. At the conclusion, the children received, besides toys, sweets and garments from the Christmas trees, each a parcel containing bread, tea (again through the generosity of Mr. Lafone), oranges, apples and crackers. The show was a hugh success and Mr. Landon deserves the very heartiest congratulations on his able engineering of the whole concern. His keenness, foresight, and judgment in an affair, the management of which is no easy matter, prevented the slightest hitch during the whole afternoon. All his helpers, too, and those friends who so kindly sent gifts of clothing and money, deserve the very best thanks of the hospital, whose reputation cannot but be still further enhanced by such a successful and benevolent entertainment.

NEW YEAR'S EVE.

All the evening the quadrangle has been dark and unlit save for the two small gas jets over the front gates

and their reflection in the occasional puddles on the sodden ground. Shortly before twelve a small crowd from the Borough begins to collect in the street outside, and presses hard against the closed iron gates. Small knots of men collect in the colonnade, and stragglers with difficulty push their way in through the crowd and stand huddled about in the dripping darkness. As twelve o'clock approaches the crowd thickens; some one calls out "Line up," and hands are joined outstretched about the dingy statue, amid desultory cheering and shouts of greeting. The President of the Residents climbs to his coveted station on the pedestal of the statue, and lights a torch of saturated tow upon a walking stick; others respond from in front and behind, and their flickering light makes the shadows dance round the straight-windowed square and fitfully illumines the circling faces. A lull comes in the babel as the minute approaches, and everybody waits expectant. Suddenly, according to time-honoured custom, the porter's bell breaks the silence, the President waves his torch, and "Auld Lang Syne" is started on the instant from a couple of hundred throats. One verse is sung and the ring begins to move right round the square; another burst of singing and then right round the square again full tear, the ring breaking, men falling and being dragged along prone in the whirl. A breathless pause, then "Three cheers for Thomas Guy" from the pedestal, and the ring dissolves into a mass of men closely clustered round the statue, cheering for all they are worth. More cheers for the Prince of Wales and the Treasurer, and then the President is hustled from his pedestal and raced round the quadrangle shoulder high among a knot of scuffling, stumbling supporters, to be set down at the end of his journey, more dead than alive, but a proud man. A sudden rush is then made to the Superintendent's house, there is frantic knocking at the door, and Dr. Perry appears. "Silence for Dr. Perry," and the noise dies down. "Gentlemen, the Superintendent goes to bed at eleven. A Happy New Year to you." A roar of laughter and cheers, and the door is closed. The torches are dying down, and popular favourites are frantically whirled round the quadrangle in the growing obscurity on unsafe shoulders, like eddies in a muddy pool. The crowd trickles away, shouting and cheering, to the dressers' rooms, and another New Year has commenced with the annual tribute of Guy's men to the famous Founder of their hospital.

THE PROBATIONERS' THEATRICALS.

January 3rd, 1899.

The Probationers' entertainment in Old Mary was splendid, that is, judging from what we could see through our peep-hole (for we were not invited, alas! we know not why). At the beginning we heard songs and music by nurses well known to us—we offer them our congratulations. The most annoying part for us was the farce, of which we could only get glimpses. One thing we did see, that Juliette was no end of a girl, and an actress too. Rumour says that she wrote the play. Nor must we forget the last thing on the programme, two well-known figures in a dialogue, not disguised in their disguise—forgive the unique pun. The refreshment tables *looked* charming covered with all kinds of dainties.

There may have been Royalty there, we don't know, but we did see the top of Dr. Perry's head in a comfortable chair alongside of the Matron; also three other heads without caps. We can't imagine who they could have been!

Appointments.

HOUSE APPOINTMENTS.

The following appointments have been made by the House Committee upon the recommendation of the Medical Committee.

House-Physicians.—Mr. J. M. Fortescue-Brickdale (Dr. Taylor); Mr. F. E. Fremantle (Dr. Pitt).

Assistant House-Physicians.—Messrs. C. Jephcott, R. T. Fitz-Hugh.

House Surgeons.—Mr. H. W. Bruce (Mr. Lucas); Mr. W. T. Milton (Mr. Golding-Bird).

Assistant House-Surgeons.—Messrs. L. H. McGavin, G. Chetwode Owsley (Surgery); A. H. M. Saward (Mr. Jacobson); W. K. Wills (Mr. Symonds); W. J. Lindsay (Mr. Lane); K. B. Alexander (Mr. Dunn).

Obstetric Resident.—Mr. P. W. Moore.

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Medical Council and approved by the House Committee:—

Clinical Assistants.—Messrs. T. P. Berry, H. L. Eason, L. E. C. Handson, R. Balderston, W. H. M. Telling, R. H. J. Swan.

Clinical Assistant in the Aural Department.—Mr. C. H. Fagge.

Clinical Assistants in the Medical Wards.—Messrs. H. Durbridge (Dr. Pye-Smith); F. O. Stoehr (Dr. Taylor); F. W. Brook (Dr. Hale White); A. E. Clarke (Dr. Pitt).

Clinical Assistants in the Surgical Wards.—Messrs. A. E. Cawston (Mr. Howse); T. J. Wright (Mr. Lucas); J. Matthews (Mr. Davies-Colley); W. Murray Thomas (Mr. Golding-Bird).

Clinical Assistants in the Medical Out-Patients.—Messrs. J. G. Taylor (Dr. Shaw); G. N. Meachen (Dr. Washbourn); W. H. Edwards (Dr. Bryant).

Dressers in the Eye Wards.—Messrs. E. J. Tongue, E. R. Row (February 1st) (Mr. Higgens); L. Wilkin, L. D. B. Cogan (March 15th) (Mr. Higgens); A. W. Nourse, H. A. Gaitskell (February 1st) (Mr. Brailey); C. B. Thomson, S. A. Ruzzak (March 15th) (Mr. Brailey).

Clerks in the Eye Wards.—Messrs. C. B. Sells, H. R. H. Denny, E. E. Parrett, E. B. Dowsett, G. N. Meachen, H. M. Reeve, H. M. Hardy, F. O. Stoehr (1st half); A. H. Carter, H. E C. Fox, H. St. A. Alder (2nd half).

Dressers in the Throat Department.—Messrs. F. S. Batchelor, A. A. Miller, G. E. Richmond, E. W. S. Rowland, A. H. B. Kirkman, T. H. W. Landon.

Clerk in the Throat Department.—Messrs. H. C. Sturdy, W. B. Hope.

Obstetric Dressers.—Messrs. O. Marriott, J. T. Dunston, C. Edwards, D. J. Munro (January 1st); H. Leader, J. B. C. Brockwell, A. G. Osborn, T. M. Walker (February 15th).

Surgeons' Dressers.—Messrs. A. H. Davies, P. D. Hunter, A. C. Lewis, H. B. Carr, E. H. Felton, A. McCabe Dallas (Mr. Howse); H. V. Bagshawe, H. A. Higgens, F. J. Felix-Jones, E. A. Miller, W. H. Brailey, T. P. Thomas (Mr. Davies-Colley); J. F. Northcott, R. C. Mullins, H. B. Foster, J. Atkins, J. C. J. Da Silva, J. S. Steele Perkins (Mr. Lucas); R. M. Barron, E. Stott, A. Fraser, E. Cohen, G. Lewin, T. E. Holmes (Mr. Golding-Bird).

Assistant Surgeons' Dressers.—Messrs. D. G. Greenfield, H. McD. Parrott, R. Tilbury, J. M. Brydone, E. J. F. Hardenberg, J. A. B. Hammond (Mr. Jacobson); T. T. Kelly, F. A. Beattie, E. Shelton-Jones, J. L. Whatley, G. Clarke, T. H. B. Dobson (Mr. Symonds); F. A. Segreda, J. E. L. Bates, S. J. Ormond, E. H. Cragg, E. T. Jensen, J. Alison Glover (Mr. Lane); R. D. Attwood, T. R. Beale-Browne, F. G. Cross, F. Curtis, W. P. Ker, E. C. Bevers (Mr. Dunn).

Medical Ward Clerks.—Messrs. A. C. Ransford, J. A. Butler, P. W. L. Camps, D. Forsyth, F. G. Gibson, A. Pearson, E. F. Reeve, R. S. Roper, H. Bentley, J. A. Wood, G. S. Graham-Smith, J. F. Robinson, K. V. Trubshaw, H. Davies-Colley, P. T. Manson, D. L. Morgan, N. F. Ticehurst, M. D. Wood, J. E. Collins, S. Hodgson, H. K. Lacey, T. A. Matthews, E. G. Wales, L. Hirsch, R. Jiménez, H. D. Kempthorne, R. P. Marshall, P. J. Nash, F. M. M. Ommanney, A. C. Osburn, S. S. H. Shannon, D. W. Smith, F. W. Smith, H. Wacher, F. E. Welchman, F. W. Sime.

Surgical Ward Clerks.—Messrs. D. R. T. Griffiths, H. A. Ehrlich, C. B. Penny, T. H. F. Roberts, W. O. Roberts, E. I. Claxton, G. G. Davidson, H. S. French, C. R. Howard, R. Thompson, E. H. Kitchin, R. D. Smedley, Angus Wylie, F. C. Wetherell, E. Bigg, F. Richmond.

Assistant Physicians' Clerks.—Messrs. W. H. Loosely, B. Muir, P. S. Mandy, F. D. Welch, G. T. Willan (Dr. Shaw); W. Johnson, E. P. Mitchell, A. Moon, K. W. Goadby (Dr. Washbourn); E. G. Andrew, J. D. Bridger, L. Pern, H. G. Rashleigh, T. B. Fawley (Dr. Bryant).

Clerks in the Skin Department.—Messrs. C. H. Brangwin, F. J. Nicholls.

Post-mortem Clerks.—Messrs. C. H. Brangwin, H. R. H. Denny (January-February); H. Braund, A. Densham (February-March).

Obstetric Out-patient Clerks.—Messrs. C. E. Hicks, H. M. Reeve, C. B. Thomson (1st half); C. A. D. Bryan, F. D. Turner, G. N. Meachen, J. H. Roberts, G. T. Willan (2nd half).

Aural Surgeon's Dressers.—Messrs. A. H. Carter, A. Reid, C. F. Watson, L. Wilkin (January–February); W. B. Hope, H. C. Sturdy, E. E. Parrett, H. M. Hardy (March–April).

Dental Surgeons' Dressers.—Messrs. R. Howard (January–February); A. D. Lewis (February–March); H. R. H. Denny (March–April).

Assistant Surgeons' Clerks.—Messrs. M. A. Collins, E. T. Jensen (Mr. Jacobson); A. C. H. Gray, L. Pern (Mr. Symonds); V. M. Wallis (Mr. Lane); F. D. Welch (Mr. Dunn).

DENTAL APPOINTMENTS.

Dental House-Surgeons (for six months from January 1st, 1899).—Messrs. A. G. G. Plumley, P. S. Campkin, E. N. Mason.

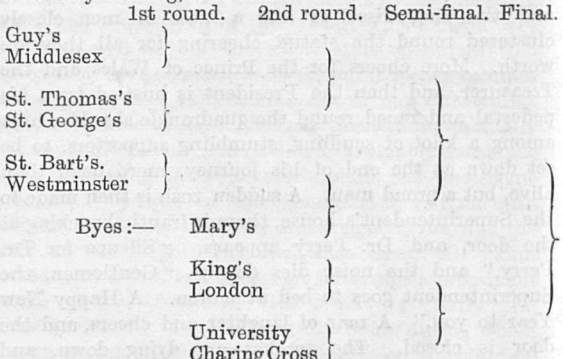
Assistant Dental House-Surgeons (for three months from January 1st, 1899.)—Messrs. P. H. Hayes Palmer, A. E. Rowlett.

Demonstrators in the Conservation Room (for six months from January 1st, 1899).—Messrs. F. W. Garman, F. J. Pearce, R. B. Recordon.

Sport.

Rugby Football.

The result of the Inter-Hospital Rugby Football Cup draw which took place at King's College Hospital on Thursday evening, is as follows:—



Births.

BERRY.—On December 25th, at Wansword House, Watford, the wife of Haycraft Berry, M.D., of a son.

HUGHES.—On December 28th, at 53, Victoria Road South, Southsea, the wife of Surgeon J. D. Hughes, R.N., H.M.S. *Tartar*, of a daughter.

MEYRICK-JONES.—On December 30th, at Guilsborough, Northants, the wife of H. M. Meyrick-Jones, M.D., of a son.

SALTER.—On December 17th, at 4, St. Nicholas Parade, the wife of Charles E. Salter, M.D., B.S. Lond., F.R.C.S., of a son.

Marriage.

TYSON-WITHERINGTON.—On December, 16th, at St. Andrew's Church, Sonning, Wilson Tyson, M.B. Cantab., of the Beeches, Lowestoft, to Maud Witherington, late Sister Cornelius.

ED.—H. L. E.

Contents.

	PAGE
THYROID DISEASE OF THE LUNG: Clinical Lecture by Dr. Hale White	21-27
HOSPITAL NEWS	27-29
AN UNUSUAL CASE OF ECLAMPSIA COMMENCING EIGHT HOURS AFTER DELIVERY	29-30
REVIEWS	30
NURSING NEWS	30
PASSIM	31-32
FROM THE GAZETTE'S SPECIAL PATHOLOGIST	32
NOTICE	32
GUY'S HOSPITAL DENTAL SOCIETY	32-35
TWO INTERESTING SWELLINGS OF LOWER JAW	35-36
CORRESPONDENCE: Mr. Landon Returns Thanks; Errata; The Treatment of Malarial and Blackwater Fever	35-36
PAPERS BY GUY'S MEN	37
SPORT: Football—Rugby: Guy's v. Old Leysians; Guy's v. Croydon; Guy's v. East Sheen. Association—Guy's v. Croydon Park; Guy's v. Weybridge	38-40
UNITED HOSPITALS' HARE AND HOUNDS	40
GUY'S HOSPITAL BICYCLE CLUB	40
APPOINTMENTS	40

Calendar of Coming Events.

Jan., 1899.

Sat. 21.—Messrs. Davies-Colley and Symonds' take-in; Drs. E. W. Goble and J. B. C. Brockwell; Cl., R. H. J. Swan.
1.15, Clinical lecture by Dr. Pitt.
G.H.R.F.C. I., Rosslyn Park, away.
II., Rosslyn Park, home.
Sat. 21.—G.H.A.F.C. I., Reigate Priory, away.
II., Carshalton Park, home.
G.H.P.P.S., "Burns and Scalds," by F. E. Walker.
Mon. 23.—1.30, Clinical lecture by Mr. Lucas.
Wed. 25.—Messrs. Lucas and Lane's take-in; Drs. C. T. Hilton and G. S. Simpson; Cl., T. P. Berry.
Thur. 26.—G.H.M.P.U., Address by Rev. Webb Peploe.
Sat. 28.—1.15, Clinical lecture by Dr. Pitt.
G.H.R.F.C. I., Marlboro' Nomads, away.
II., Redhill, away.
G.H.A.F.C., I., Ipswich, away.
II., Eversleigh, away.
Mon. 30.—1.30, Clinical lecture by Mr. Lucas.

February.

Wed. 1.—Messrs. Golding-Bird and Dunn's take-in; Drs. E. Stott and T. J. Wright; Cl., L. E. C. Handson.
Thur. 2.—G.H.M.P.U., Address by Rev. A. W. Evans.
Sat. 4.—1.15, Clinical lecture by Dr. Pitt.
G.H.R.F.C. I., Catford Bridge, home.
G.H.A.F.C. I., Ewell, home.
II., Ewell, away.
G.H.P.P.S., Pathological Meeting.

Guy's Hospital Gazette,

JANUARY 21, 1899.

Fibroid Disease of the Lung.

CLINICAL LECTURE BY DR. W. HALE WHITE.
December 3rd, 1898.

GENTLEMEN,—When I have shown this boy to you he can go away, and we can talk about him. He is eleven years old, and he comes into the hospital for shortness of breath. His family history is of no importance. He had measles when he was quite a baby. Three years ago he had pleurisy, for which he was in bed six weeks. He has not been strong, and has had shortness of breath, especially on exertion, since then. The right chest has gradually been getting flatter and flatter, and now you see that it is very flat indeed. His right shoulder has been falling. He has had a cough, but that has got less. He has sweated a little at nights, but does not sweat now. Two years ago he is said to have coughed up a little blood, and he is said to be losing strength.

Now let us take the physical signs. It is obvious to you, as you see him there, that the right chest is flat. This comes out very well in some photographs that we have had taken, and which I show you. The great flattening of this (right) side is very striking.

As proof of the great extent of flattening or falling in, look at the difference in the size and shape of the two sides of the chest, as shown by these cyrtometer tracings. This is one taken in the nipple-line, and the measurement on the right side is nine and three-quarter inches, as against twelve and a quarter inches on the left side. Then half an inch above the nipple you see a greater difference between the sides—I think the falling in is as much as I have ever seen—nine and a half inches on the right side as compared with twelve and a quarter inches on the sound side. And at the junction of the xiphoid cartilage with the sternum, it is ten and three-quarter inches on the right side, against twelve and a quarter inches on the left. So that the whole of the chest on the right side shows a very great falling in.

Then next, there is a curious displacement of the clavicle. The clavicle, as a result of the falling in of the chest, has been drawn downwards and backwards, with the result that it is very easily movable at its sternal articulation, and it is drawn away from its attachment to the acromion process, so that the ligaments attaching it to this process are much stretched. Very likely this is not visible at a distance, but if you are close to the boy you will see it.

Another result of the falling in on the right side of the chest, is, you see, that owing to the falling together of the ribs there is a curvature of the spine, with the concavity of the spine towards the fallen-in side, and of course the convexity of the spine away from the fallen-in side. I notice in one or two books there is some confusion as to the curvature of the spine in these cases in which the chest falls in. If you think for a moment, when the chest has fallen in, it must have the concavity towards the fallen-in side, and the convexity away from it. Mr. Owsley has marked the spinous processes, and you see the main curve, and that the patient has compensatory curves in his cervical and lumbar regions.

Mr. Owsley has also marked out the ribs. There they are on the sound side, and here they are on the fallen-in side. I have never seen ribs so close together before. So close together are they that I do not think we could put an exploring needle into the chest.

The next point I want to draw your attention to is, that the right side of the chest does not move at all. (At the request of the lecturer, the boy here drew a breath to demonstrate the point.) There is complete immobility on the right side of the chest.

I do not think, seeing the distance you are from me, there would be much gained by my percussing the chest before you; you would not hear the note at that distance. But what we do find is very interesting. First of all, at the back it is dull from the top down to the base. The dulness is more marked at the base than at the apex. In front it is dull except for about two inches to the right of the middle line, and here there is a skodaic note, which is clearly due to the fact that under all the rest of the right chest wall we have something producing a dull note, and so we get a skodaic note along the front. The resonance of the left side is healthy.

On listening to his breathing, we hear that little air enters the right side; on the other side the breathing is compensatory. On the right side the breathing is rather bronchial, and in the middle of the lung, especially in the axilla, it is cavernous or amphoric. There are no moist sounds at all, bronchophony is a little increased, and there is some pectoriloquy on the right side. There is no cracked-pot sound, no *bruit d'airain*, and no metallic tinkling sound.

With regard to the left lung, there is, as I said, compensatory breathing, and we think a little emphysema. The resonance of the left lung does not come over beyond the middle line, and we find, going over it carefully, that the apex of the left lung appears healthy.

In regard to the heart, you would think that with all this falling in of the right chest, it would be dragged over to the right side, but as far as we can determine the heart is normal in position. We cannot feel the liver even on the deepest breathing, so that I think we may fairly conclude that, owing to the drawing up of the diaphragm with this general shrinking on the right side, the liver has been drawn up too.

The last point to which I want to direct your attention is very striking. I think you can almost see at that distance the great clubbing of the fingers. If you cannot, the photograph I have here shows it very well. And what is more remarkable, all the toes on both feet are clubbed. You will see that when toes or fingers are clubbed, the terminal phalanges are swollen at their underneath part, the nails over them are curved and livid.

These are the only physical signs we need discuss in connection with the patient. I have told you the history, and I think, therefore, the attendant can now take him away.

Well, now I want to go over with you the causes of this condition. You have only to look at his chest to see that by some means or other that right lung is contracted. It cannot be normal in size with the chest that shape; therefore, we have got to think of all the causes for contraction of the lung. It is a very obscure subject, and so I want your close attention.

I think it will be best if I write down for you the possible conditions that might cause that shape of chest. Some of you in the ward suggested that it might have been due to his pleurisy in some way. That is quite correct. And so the first thing that we will write down as a possible cause is *old pleural effusion*. What sometimes happens is this: a quantity of fluid is effused into the pleural cavity; as the result of this the lung is compressed, and if that fluid is re-absorbed and the lung does not re-expand, the chest falls in to make up for the deficiency of contents in the pleural cavity. I have no doubt that that is not what has happened with this boy. There are no signs of fluid now, and I cannot imagine such a complete falling in due to this cause, for if enough fluid had been exuded to make the lung as small as it is in this case, all the fluid would not have been re-absorbed. The falling in that you get when the fluid is only partially absorbed

and the compressed lung does not expand, is quite slight. But I have known men fail to find fluid, because they have said there cannot be any fluid as the affected side is smaller than the other. There may be fluid when the affected side is smaller than the other. If there is, the affected side is only a little smaller than the other.

The second possible cause for the state of this patient's chest is that a long while ago he had an *empyema*. Now what would happen in that case is this: the empyema would compress the lung, and the thickened inflamed pleura would bind down the compressed lung back against the spine. Next we must suppose the pus to be discharged, but the lung to be bound down against the spine, so that it could not re-expand, and consequently the chest would fall in. The fatal objection to this view is that there is no history of such a condition. We could see the scar if the boy had been operated upon for empyema, or if it had discharged externally of its own accord, and we should also know from the history if he had coughed up an empyema big enough to cause such a falling in of the chest; so the evidence is decidedly against this view.

Here is a specimen of lung (produced) showing the sort of thing we have just discussed. There has been an old empyema. Here is the compressed lung, with a number of dilated tubes in it. The compression of the lung has made it fibrous, and the specimen shows the sort of thing which I am suggesting to you this boy cannot have. The compression of the lung that will take place when there is a great deal of fluid is wonderful. If you read Osler's Text Book you will find there an anecdote of a doctor who made a *post-mortem*, and said the patient on whom he made the *post-mortem* had only one lung, because the other was compressed into such a small space. I too have heard the mistake made. When I was a house-physician one of my fellow-students, who was making an autopsy, said, "This child has only got one lung," and it took us some time to find the other lung, because an old empyema had compressed it to much less than the size of my hand, and it was reduced to a little fibrous mass lying compressed back against the side of the spine. I remember a woman who died in the Clinical ward five years ago. Her right chest was full of hydatid cysts; they were removed during life, and filled a washhand-basin. Her lung never re-expanded, and it also was found compressed to a size rather less than that of my hand.

Now let us consider if the state of our patient's chest can be due to any disease starting in the lung? And, first of all, we will take what one of you suggested when he first came in, namely, *a cavity in connection with tubercle*. You often hear people talk about the contraction of phthisical cavities, but I have never seen and never read of any evidence that a large cavity can contract. There is no doubt that in the post-mortem room you often see a number of fibrous bands radiating away from a point in the apex of the lung, but if these represent a healed contracted cavity it must have been a very small one. And you will agree with me, if you come to think of your experience of *post-mortem* examinations, that you have no evidence that a cavity could cause such an enormous falling in as you saw in our patient, and I assure you that you may put this possibility out of mind at once.

The next possible cause for the falling in of this patient's chest is what is called *fibroid disease of the lung*. This is due to many causes, each of which I will put upon the blackboard. By far the commonest is (a) *chronic tubercular phthisis*, due to the tubercle bacillus. I picked out this specimen of this condition from the museum, and you see there is an enormous amount of fibrous tissue in the lung, great strands running right through it. This change is all due, presumably, to the tubercle bacillus, and it is surprising how much a chest will fall in from the contraction of fibrous tissue, which results from the irritation produced by the tubercle bacillus. This condition is called fibroid phthisis, and remember it is a healing process. A case of tubercular disease of the lung is doing well in proportion as the chest falls in, for that means that the lung is healing and that the fibrous tissue, like other scar tissue, is contracting. Tubercle is a much commoner cause of fibroid disease of the lung than all the other causes put together. So common indeed is it, and so chronic are some of the cases, that in every case of fibroid disease of the lung, before you for certainty declare it is not tubercular, you must prove that tubercle bacilli are never present in the sputum, and you must wait for a *post-mortem* and prove that no tubercle bacilli are present in the lung after death. I do not think that tubercle bacilli are causing fibroid disease of the lung in our boy, but I cannot be sure. My reasons for this view are:—The other lung is absolutely healthy, and it is almost inconceivable that the boy could have so much disease on the right side from tubercle, and none on the left, and further you will remember also that he has

no moist sounds on the right side, and with tubercle we should have expected a few. But, on the other hand, it is true he is said to have sweated and wasted. But I do not think this signifies much in patients if they are badly fed and looked after. And he has some occasional irregular, slight pyrexia, but in a boy as ill as he is this does not necessarily indicate tubercle. It may be due to his dilated tubes. Balancing, therefore, all the reasons, although I cannot be certain until after death, I am inclined to think this is not a case of fibroid tubercular phthisis. Unfortunately the boy does not expectorate.

The next thing we may put down as a cause of fibroid disease of the lung is (b) *inhalation of dust*, or, as it has been called, pneumoconiosis; in these cases chronic inflammation of the lungs is set up by dust. In some trades this disease, usually produced by the inhalation of iron, coal, or stone dust, is very common, and before the tubercle bacillus was discovered, dust was thought to be the sole cause of many diseases of the lungs. But, in the first place, our boy has followed no dusty occupation, and secondly, fibroid disease of the lung due to dust is always bilateral, but our boy's disease is unilateral. Moreover, this pulmonary disease is only met with in adults. And further, while it appears probable that sometimes fibroid disease of the lungs is entirely due to dust, most of the cases thought to be due to dust are due to dust and tubercle bacilli combined. The dust sets up a chronic bronchitis, and the tubercle bacillus flourishes in the diseased lung.

Another cause that has been given for fibroid disease of the lung is (c) *pneumonia*. From my own observation I know nothing about this. It is mentioned in the text-books. Once or twice I have thought it possible, when a patient's pneumonia did not clear up before his going out of the hospital, that his lung was commencing to be fibroid. But I have never met such a case come back again with fibroid disease of the lung, and all authors say that this result of lobar pneumonia is very rare, if it exists. Our museum does not contain a single specimen, and our patient gives no history of having had pneumonia. Probably at present it is quite incapable of proof whether or not pneumonia is a cause of fibroid lung.

Then (d) *broncho-pneumonia* is said to do the same thing. Well, there again I am sorry to say I personally have no knowledge of it. I have never seen a case; our museum does not contain a specimen. Numbers of writers say it is fairly common, others say it does not occur. All I can say is that you had better wait, before making up your minds, until some evidence is forthcoming. Many people would say, that as our patient is a child it is very likely that broncho-pneumonia was the cause of fibrosis in his case. Some of those who believe that broncho-pneumonia is a cause of fibroid disease of the lung, think that it is particularly likely to follow the broncho-pneumonia set up by measles and whooping-cough. This cannot bear upon the question in our boy, because he has not had whooping-cough, and he had measles when he was quite a child, but the present illness did not begin until he was eight years old.

Now we come to another supposed cause, and again, I am sorry to say that personally I know nothing about it. Sir Andrew Clarke was of opinion that some cases of fibroid disease of the lungs met with in later life are due to persistent (e) *chronic bronchitis*, quite apart from tubercular fibroid disease. I know of no proof that this opinion is correct, and it does not bear upon our patient, as he is not an adult.

The next cause to be mentioned is (f) *collapse* of the lung. It is a well known histological fact that a collapsed lung after a time tends to become fibrous. But this is not of clinical importance to us, for no ordinary cause of pulmonary collapse would lead to such extensive fibrosis as to make the whole of one side of the chest fall in.

Everybody will agree that (g) *malignant disease* of the lung may cause fibrosis of it. But this also, although important to the morbid anatomist, is of no clinical interest to us to-day, for malignant disease of the lung has its own distinctive characters. I only put it in our list for the sake of completeness. Our boy has none of the symptoms of it, and is too young to suffer from it. Secondary deposits are not uncommon, but primary malignant disease of the lung is excessively rare.

In very rare cases (h) *injuries* will make a lung fibroid. Cases are on record in which broken ribs have been driven into the lung, and fibrous bands have radiated out from the damaged part, but this is nothing more than the fibrosis of an ordinary scar.

Also in very rare instances (i) *a foreign body*, if it remains in the bronchial tube for a long while, will set up dilatation of the tubes, collapse of the lung and fibrosis. Often a foreign body causes much more harm than this, because it is septic when it is inhaled, and sets up gangrene.

Another cause of fibroid lung is (j) *aneurism*. It acts either by pressing on a bronchus and so

causing collapse, or by direct compression of the lung. Obviously the last three causes do not bear on our present case.

Now we come to a very important question indeed. It is certain that (k) *syphilis* may cause fibrosis of the lung. Is it possible that this boy's lung is syphilitic? There is so much confusion in the minds of students about syphilis of the lung that we will discuss the changes due to both acquired and congenital syphilis, although, of course, only the second bears on our case.

As regards congenital syphilis, what do the books say about it? They tell you it will produce in the lungs, first of all, a white consolidation. It is said that the lung is quite solid, airless, and sinks in water. Histological examination is said to show that the alveoli are full of cells, and that there is much fibrous tissue in the lung. This condition is said to be found chiefly in still-born infants, and no clinical signs have been described, because if the child is not still-born, it generally dies within a few hours of birth. Good observers have stated that this condition of lung exists, and it seems difficult to disbelieve it. But there is not a single specimen of it in London museums. I have never met anyone who has told me that he has ever seen it, and all the text-books I know copy the same description. So that all you can say is, if this condition of thing exists it must be very rare indeed. I have often said that I wish some of you who are working in the Maternity Department would take the matter up and see if you could thoroughly work out the question of congenital visceral syphilis. Congenital syphilis is also said to produce gumma of the lung. This, too, must be infinitely rare, because there is no specimen in London museums of it; in fact, there is, I am told, no specimen in any London museum of congenital syphilis of the lung at all. This will give you some idea of how rare it must be. It has been said in some books that congenital syphilis may cause pneumonia. That is in all probability not correct. Children suffering from congenital syphilis no doubt often develope broncho-pneumonia, but this is probably because the subjects of congenital syphilis are weak and have no resisting power, and therefore all we can say is, that congenital syphilis predisposes to this disease. It is quite clear that congenital syphilis could not cause the condition we saw in our patient.

For the sake of completeness, we will for a few minutes leave him, and discuss the effects of acquired syphilis on the lung. I have sometimes demonstrated to you in the wards that some patients with bronchitis quickly get well if given iodide of potassium, even when other remedies have failed, but I do not know that we ought therefore to conclude that syphilis may cause bronchitis. Nevertheless, it is important to remember the clinical fact that apparently intractable bronchitis will often yield to iodide of potassium.

There is no doubt whatever that acquired syphilis can produce a gumma in the lung. We have some beautiful specimens in the Guy's Museum. I have brought one here, so that you can see it after lecture. It shows a number of little gummata scattered throughout the lung, and a very beautiful and valuable specimen it is, because gummata of the lung are very rare.

Nor is there any doubt that very rarely acquired syphilis may cause fibrosis of the lung. Sometimes the fibrosis spreads in from the root. Our museum has not got a specimen definitely illustrating this, but as you see here it has one showing patchy fibrosis due to syphilis, for in this specimen you will see that the apex of that lung is distinctly more fibrous than the rest. That fibrosis has been proved not to be tubercular. The patient had well-marked manifestations of syphilis, and there is no doubt that the fibrous disease of the lung is syphilitic. Sometimes the fibrosis is diffused, as it is in this other extremely valuable specimen, where a diffused fine fibrosis is visible throughout the lung.

Thus there are the two things that acquired syphilis can directly do to the lung itself. It can produce a gumma, and it can produce a fibrosis which either spreads in from the root, is patchy, or is diffused throughout the lung. It also has been said to produce a chronic pneumonia, but this is probably incorrect. But none of these effects of acquired syphilis are of much clinical importance; they are so very rare and are rarely suspected until found in the post-mortem room.

So far as I know, by far the most important pulmonary symptoms which can be ascribed to syphilis are those which follow syphilitic stenosis of the bronchi, for this, like any other bronchial stenosis, will produce destructive changes in the portion of lung connected with the stenosed bronchus. No doubt many cases which, before the discovery of the tubercle bacillus, were called syphilitic phthisis, were really instances in which the stenosis of a bronchus had led to non-tubercular destructive changes in the lung. But you must remember

that people who have syphilis are very liable to tubercular phthisis. I have seen two or three cases illustrating that fact, and it is remarkable sometimes to see the rapidity with which tubercular phthisis runs its fatal course in those suffering from syphilis. So that not until repeated examinations have failed to find tubercle bacilli, must you assume that the destructive changes in the lung result solely from syphilitic bronchial stenosis. To show you how rarely acquired syphilis damages the lung, I may mention that the only clinical instance that has ever come under my care was one in which stenosis of a bronchus produced pulmonary destructive changes, and the author of the article on Acquired Pulmonary Syphilis, in Morrow's great work, only gives four cases of syphilitic disease of the lung, and three of these are doubtful.

To return to our patient, the last possible cause for the condition of his chest is (l) *a combination of fibroid disease of the lung and old pleurisy*. There are on the table many specimens illustrating this condition, and you can see them afterwards. What I have before me in my mind is that in the boy's chest we should find his pleura white, dense and very thick. I have made a *post-mortem* in a case in which it has been half an inch thick. Probably this boy's lung would have to be carved out of the chest because the two pleural surfaces are firmly adherent. And when you cut a section through the lung, you would find that from this thickened pleura great white strands of fibrous tissue would run into the lung, and from these again smaller strands, suggesting that the fibroid disease of the pleura was primary and that the pulmonary fibrosis grew from it. So that you would have really a combination of thickened fibroid pleura together with fibroid lung. Also you would see, that owing to the contraction of the fibroid tissue, the bronchial tubes were much dilated, and that the falling in of the chest was due to the contraction of the thickened pleura and to the contraction of the fibrous tissue in the lung.

What form of pleurisy this condition follows I do not know. We know many forms of pleurisy, pneumococci, staphylococci and tubercle bacilli have all been proved to cause pleurisy, and it follows typhoid fever, influenza, rheumatic fever, Bright's disease, scarlet fever, and other specific fevers, but we do not know what is the cause of the condition I am describing, and many authorities, while admitting as correct the description I have given you as to what we ought to find in this boy's chest, would say, "Yes, but very likely in addition to his pleurisy his original illness was partly due to pneumonia." That cannot be settled, but the kind of thing I want you to carry away with you in your minds, as to what we should expect to find in this boy's chest, is what I have described to you, and what many of these specimens before you show.

Let us quickly run over the chief physical signs and symptoms that are produced by this enormously thick adherent pleura which is associated with fibroid disease of the lung, and is followed by falling-in of the chest. The affected side of the chest is compressed flat, as in our boy, the ribs are close together, the spine is curved, the shoulder drops, the clavicle is drawn out of its place, the chest is immobile, and the note is dull. And it is important to remember that in nearly all these cases the dulness down the back increases from above downwards, presumably because there is a greater thickness of fibroid lung and pleura at the base than at the apex. It is so in our boy, and that, I think, is strong evidence that his present condition of lung originated in pleurisy.

Then there is an impaired entry of air into the affected chest. There is also some bronchial breathing which becomes cavernous over the middle line of the lung. This is because in these cases the tubes are always dilated, and those in the middle of the lung are large enough when dilated to give rise to cavernous or amphoric breathing.

Very often moist sounds can be heard, because the dilated tubes usually have some fluid in them, and if there are moist sounds they will consonate because of the solidification of the lung by fibroid tissue. Whether or not there is bronchophony depends on the thickness of the pleura. If the pleura is very thick there is no bronchophony; if the solid lung is the chief feature the bronchophony is increased. For the same reason the pectoriloquy is variable.

The breathing in the unaffected lung is compensatory, and the lung itself may be a little emphysematous. Very often its resonance goes over beyond the middle line and obscures the cardiac or hepatic dulness, as the case may be.

The heart is frequently dragged much out of position by the contracted lung, and our case is quite exceptional as this is not so. Sometimes you can make out that the right side of the heart is dilated as a result of the increased work necessary to drive the blood through the diseased lung.

If the fibroid lung is on the right side, the liver gets drawn up and cannot be felt unless the backward pressure through the

circulation is great enough to enlarge it. And if the fibroid lung occurs on the left side the stomach may be dragged up, so that you can elicit resonance a long way up into the axilla.

Then there comes the most remarkable of all the conditions, namely, the clubbing of the fingers and toes. I have read somewhere that sometimes the nose is clubbed, but I have never seen such a curious result of fibroid disease of the lung.

Clubbing of the fingers and toes, which is more often and most markedly seen in the fingers, is symptomatic of chronically impaired circulation through the chest and is due to long-standing venous congestion at the periphery of the circulation. It is most commonly seen in fibroid disease of the lung, in empyema, phthisis, and congenital disease of the heart, and it occurs in 75 per cent. of all cases of fibroid disease of the lung, but cyanosis is rare.

With regard to other symptoms, the cough often lasts many years and there is usually dyspnœa, but only on exertion. Occasionally there is hæmoptysis because the tubes have dilated. The expectoration, of course, is very variable, depending upon the bronchitis and dilatation of the tubes associated with the fibrosis. If the dilated tubes are very numerous you have the characteristic expectoration of dilated tubes. Occasionally there is epistaxis with the coughing.

What is very striking, as showing that these cases are not tubercular, is that the patients do not look ill, they do not feel ill, and they live ten, twenty, thirty, forty, or even fifty years. If we are correct in assuming that that boy has not tuberculous disease of his lungs, he may very well live another thirty years. Probably if he were properly fed he would look well and not complain much, except of dyspnœa on exertion.

If, in non-tubercular fibroid disease of the lungs, there is much backward venous pressure, there may be dyspeptic symptoms and slight œdema or albuminuria, and if the dilated tubes are very prominent, there may be septic absorption of retained secretion, with consequently a slight rise of temperature and some diarrhœa.

The common and important complication of this disease is bronchiectasis. The tubes dilate because of the contraction of the fibrous tissue of the lung, and the secretions in them are consequently retained. We should need another clinical lecture to go over all the whole subject of dilated bronchial tubes. Sometimes the increased secretion becomes so foul that gangrene of the lung is set up, and this is one cause of death among those who suffer from fibroid disease of the lung.

The variety of fibroid disease of the lung from which we believe this boy to be suffering is not seen in children under five years of age, nor in adults of forty or fifty. It generally occurs in persons of from ten to twenty years of age—that is to say, in elderly children and young adults.

I have already impressed upon you the extreme chronicity of the disease, and the last fact for you to remember is, that this non-tubercular fibroid disease of the lung is much commoner on the left than the right side. In our boy it is not on the usual side.

You will give the parents such directions about a patient's mode of life as your common sense suggests, and treat complications as they arise. Want of time prevents a fuller discussion of treatment.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

CASES UNDER DR. PYE-SMITH.

MARY	27.	Recurrent gastric ulcer. Apical systolic bruit.
	28.	Mitral regurgitation. Ascites.
	29.	Hæmaturia.
	32.	Gastric ulcer. Hæmatemesis.
	33.	Mitral regurgitation.
	36.	Phthisis.
	37.	Splenic enlargement. ? Leuchæmia.
PHILIP	23.	Malaria. Gall stones.
	25.	Right basal lobar pneumonia.
	27.	Empyema. Operation.
	30.	Phthisis, right apex. Cirrhosis of liver.
	33.	Empyema.
	34.	Chronic Bright.
	35.	Bronchitis.
	37.	Rheumatism. Pericarditis.

CASES UNDER DR. TAYLOR.

MARY	38.	Chronic interstitial nephritis. Uræmic fits.
	41, 49.	Acute rheumatism.
	43.	Chronic osteo-arthritis. Subcutaneous fibromata.
	45.	Typhoid.
	50.	Bronchitis. Enlarged liver. Jaundice. ? Cirrhosis.

STEPHEN 4, 7, 15. Enteric.
5, 17. Mitral stenosis.
11. Mitral regurgitation and double aortic disease.
13. Post-hemiplegic condition.
14. Malignant growth of the œsophagus.
20. Diabetes mellitus.

CASES UNDER DR. WASHBOURN.

PHILIP 2. Plumbism. ? Malignant disease.
3. Acromegaly. Temporal hemianopia. Optic neuritis.
6. Ulcerative endocarditis.
7. Bronchitis.
8. Cirrhosis of liver.
10. Hemiplegia.
11. Peripheral neuritis after influenza.
17. Mitral disease. Tricuspid regurgitation.
19. ? Stricture of pylorus.

MARY 13. Mitral stenosis. Epilepsy.
16. ? Movable kidney.
23. Purpura hæmorrhagica.

CASES UNDER DR. BRYANT.

MARY 2, 6. Phthisis.
3. Malignant disease of liver.
4. Psoriasis.
8. Enterica.
9, 11, 52. Lobar pneumonia.
51. Broncho-pneumonia.

STEPHEN 21, 31, 37. Lobar pneumonia.
22. Enterica.
23. Chronic perihepatitis. Peritonitis.
24. Acute nephritis.
25. Chorea. Mitral regurgitation.
27. Psoas abscess. Phthisis.
28. Psoriasis.
29. Dilated stomach.
33. Acute rheumatism. Mitral regurgitation.
34, 35. Aortic disease.
36. Carcinoma of pylorus. Jaundice.
38. Chronic mediastinitis.
39. Cerebral hæmorrhage.
40. Chronic bronchitis.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

CHARITY 6. Burn.
11. Fractured patella.
Cot C. Burn.
E. Tuberculous testes. Right castrated.

NAAMAN 5. Inflamed cæcal femoral hernia. Herniotomy and artificial anus formed. Resection.
6. ? Malignant glands in neck. ? Primary carcinoma.
9. Rodent ulcer of face.
12. Hæmaturia. ? Vesical.
15. Cystic parotid tumour. Excised.

ASTLEY COOPER 5. Bullet wound in skull. Not extracted.
7. Compound dislocation of elbow.
13. Fractured femur.
16. Double compound fracture of tibia.
21. Fractured femur. Synovitis of skull.
23. Fracture through old excised knee.
32. Fractured femur. Hodgen's splint.

CASES UNDER MR. DAVIES-COLLEY.

LUKE 2. Median paralysis from callus pressure after fractured humerus. Callus resected.
4. Rodent ulcer. Excised and plastic operation.
8. Old fractured patella. $\frac{3}{4}$ inch separation. Previous splint treatment.
9. Enlarged prostate.
12. Epithelioma of tongue. Excision.
12. Hydrocele (left) and cyst of epididymis (right).

LYDIA 4. Whitlow. Finger amputated.
17. Acute infective periostitis of tibia. Incised and drained.
21. Congenital talipes equino-varus (right).

CORNELIUS 5. Double compound fracture of tibia and fibula.
6. Fractured femur.
18. Pott's fracture.

CASES UNDER MR. LUCAS.

ASTLEY-COOPER 2. Fractured patella.
13. Fractured femur.
31. Depressed fracture of vertex. Bone raised.

JOB 3. Vesical hæmaturia. ? Villous tumour.
20. Gluteal abscess. Spinal caries.
23. Cyst of testicle. Excised.

LYDIA 16. Tuberculous tarsus.

CASES UNDER MR. GOLDING-BIRD.

LAZARUS 6. Recurrent appendicitis. Appendicectomy.
12. Tuberculous testis. Castration.
13. Hypertrophied prostate.
20. Dislocated shoulder. Reduction by operation.

MARTHA 3. Bronchocele. Excised.
17. Tuberculous pectoral abscess from rib caries.

ASTLEY COOPER 5 & 17. Pott's fractures.
9. Compound fracture of internal epicondyle of humerus.

CORNELIUS 8. Fractured sternum. Diffuse emphysema.
14. Ruptured ileum without external wound. Laparotomy and resection, using Murphy's button. Death.

CASES UNDER MR. JACOBSON.

SAMARITAN	11.	Popliteal abscess.
VICTORIA	4.	Iliac abscess and hip disease.

CASES UNDER MR. SYMONDS.

LUKE	16.	Tuberculous laryngitis. Tracheotomy.
JOB	10.	Epithelioma of tongue.
MARTHA	15.	? Adenoma. ? Sarcoma of thyroid. Excised.

CASES UNDER MR. LANE.

VICTORIA	6.	Leontiasis ossea. Chiselled away.
	7.	Moveable kidney. Nephrorrhaphy.
JOB	12.	Epithelioma of tongue.
	14.	Vesical calculus.
	15.	Otorrhœa.

CASES UNDER MR. DUNN.

MARTHA	10.	Carcinoma of hepatic flexure of colon.
Cot C.		Talipes equino-varus.
LAZARUS	2.	Charcot's disease of hip. Locomotor ataxy.

Cases in Queen Victoria Ward.

1. Ovariotomy.
2. Carcinoma of uterus.
3. ? Hæmatocele. ? Perimetritis.
4. ? Hæmatocele.
6. Contracted pelvis. Cephalotripsy.
7. Extra-uterine fœtation. Hæmatocele.
8. Ruptured perineum.
9. Incomplete abortion.
10. Ovariotomy.
12. Ruptured perineum.
13. Fibroid. Phlebitis.
14. Ruptured perineum.
15. Ovariotomy.
16. Curetting.
18. Epithelioma vulvæ.
20. Polypus uteri.
21. Fibroid. Hysterectomy.
22. Ovariotomy.
23. Malignant ovarian tumour. Laparotomy.
24. Ventral hernia.

"Clinical."

1. Acute nephritis.
2. Enterica.
3. Pyopneumothorax. Phthisis.
4. Empyema. Drained.
5. Diphtheria. Tracheotomy.
6. Enterica.
7. Pleuritic effusion. Rheumatic origin.
8. Appendicular abscess.
9. Acute appendicitis. Suppurative peritonitis.
10. Congenital cardiac disease. Bronchitis.
11. Enterica.
12. Hydronephrosis.
13. Appendicular abscess opened in left groin.
15. Elephantiasis.
16. Acute bronchitis and pleurisy.
17. Asthma and bronchitis.
18. Enterica.
19. Aneurysm of arch of aorta.
20. Carbolic acid poisoning.
21. Acute nephritis.
22. Puerperal broncho-pneumonia.
23. Mitral stenosis and regurgitation.
25. Abdominal tumour. ? Renal.
26. Pleuritic effusion. Rheumatic.
27. Pleuritic effusion.
28. Pleuritic effusion.
29. Enterica.
30. Chlorosis.
31. Mitral stenosis and regurgitation
33. Post-diphtheritic paralysis.
34. Pneumococcal-pneumonia.
35. Broncho-pneumonia.
36. Intussusception. Reduced by inflation.

"An unusual Case of Eclampsia" Commencing Eight Hours After Delivery.

Perhaps the following case may be of interest. M. B., æt. 18, primipara, unmarried, was delivered naturally at 9.30 a.m. on December 21st. Not having previously seen patient, I was unaware that she had anasarca, legs being œdematous and purple. However, all went well until *6.30 p.m.*, when I was suddenly called to her, and found her exceedingly convulsed. The convulsion soon passed off. At *8 p.m.* I was sent for again. First I injected Hyoscine, then patient being able to swallow, gave Bromide of Potassium, Chloral Hydrate and Pot. Bitart. The convulsions recurred at *9 p.m.* At *10 p.m.* they again occurred, and continued until *4.30 a.m.* During part of this time I had her under Chloroform. The convulsions continued more or less until 12 noon. The fits were so violent that three or four women were quite unable to control her. I commenced treatment by giving hypodermic injection of Hyoscine, then Chloral Hydrate and Pot. Bromid. with Pot. Bi-tart. Then at *10 p.m.* (having Chloroform with me) I administered Chloroform heroically until after several hours I had to cease by reason of vomiting, so severe that she all but suffocated in the fits. The Chloroform was in my opinion of little service, it kept her quiet and that is about all. Then I had recourse to hypodermic injection of Morphia gr. one-third. This was of no use, so after a while I gave gr. two-thirds with manifest advantage, and some time after I repeated this dose. The Morphia in heroic doses acted like a charm and controlled the convulsions effectively. From 4.30 a.m. to 12 noon she only had an occasional slight

convulsion. The urine proved highly albuminous. After a course of Pot. Bi-tart and Quassia all symptoms disappeared, and she made a perfect recovery in a fortnight.

The peculiar features of this case were the uselessness of Chloroform and the utility of Morphia in big doses, and the late onset of the symptoms.

Newcastle-on-Tyne. W. H. SPURGIN.

Note.—Not having Pilocarpine, I could not try that.

Reviews.

General Nursing. By Eva C. E. Lückes, Matron to the London Hospital.

Miss Lückes' Manual on General Nursing is, without doubt, a very excellent one, and shows the result of many years' practical experience, a greater part of which has been gained in our largest London hospital.

The book was first published in 1884, and since then many additions have been made, chiefly in the form of lectures, which have been revised and incorporated in the present edition. In the opening chapters, Miss Lückes gives much sound advice, which not only probationers but nurses already trained would do well to follow. Her desire, following in the footsteps of Florence Nightingale, is to raise the moral tone of the nursing profession and make it, as she herself remarks, an art rather than a profession, humane and practical rather than theoretical and mechanical. Nurses who are now doing private work will find many valuable hints given as to the more modern aseptic treatment of surgical work. Clear and concise directions are given as to the making of beds and preparing for all operations, also hints as to the nursing of tracheotomy cases, making poultices, and other everyday matters in nursing. There are also some excellent remarks on the treatment of ophthalmic cases, a branch of work often missed in general hospital training. To conclude, this book may be safely recommended as being well worth any nurse's careful study.

Gant's Guide to the Examinations of the Conjoint Board. 7th edition. Revised throughout by Willmott Evans, M.D., F.R.C.S. 5s.

We have only to record the appearance of the seventh edition of this excellent little book. It contains the syllabuses of work for all the College examinations, and also examination papers for the last few years, together with specimen *vivas* in all subjects. It has been thoroughly revised, and should prove most useful to all Conjoint men.

A Pocket Medical Dictionary. By George M. Gould, M.D. (London: H. K. Lewis). Price 2s. 6d. net.

This very concise and useful little dictionary is compressed to absolutely its smallest limit. It is very small and will go easily into the pocket, and is printed on very thin paper, so that 300 pages are only about ½-inch thick. Sandwiched in between are tables of arteries, muscles, temperature, scales, bacilli, etc. It is essentially a book for a busy man, and has the advantage of being moderate in price.

Essays for Students. By Stephen Paget, F.R.C.S. London: Bailliére, Tindal & Cox. Demy 8vo, pp. 178. 3s. 6d.

Four excellent essays, on Strangulated Hernia, Cancer of the Breast, some Run-over Cases, and Elements of Aural Surgery, respectively. As Mr. Paget says in the preface, they are written for Students only, to illustrate cases that are common in hospital practice, and he also modestly adds, "men who have made good use of those books that are complete and necessary may yet care to read something that is neither the one nor the other."

All four subjects are treated in Mr. Paget's usual fascinating style, and are excellent reading. The article on Strangulated Hernia is exceedingly well done, and it should be worth the while of any house-surgeon to read, mark, learn, and inwardly digest it.

In "Some Run-over Cases" the question of laparotomy in abdominal injuries where there is suspicion of ruptured gut, is fully discussed, and Mr. Paget inclines rather to discourage immediate operation, and to rely on absolute rest, morphia, careful nursing, etc., though at the same time the surgeon should be ready to interfere at any hour.

Following this article there is an interesting note on cases of voracious hunger and thirst following head injuries, caused, in Mr. Paget's opinion, by injury to the cortex in the neighbourhood of the speech centres, probably in close relation with the olfactory centres in the temporo sphenoidal lobe. But quotation in a brief review is unfair to the writer, and the book itself should be read by all who come in contact with casualty cases in a large hospital.

Nursing News.

We are glad to be able to report that Nurse Press has recovered from the severe attack of rheumatism from which she has been suffering, and has now gone away for rest and change. Later on she intends joining the Staff of our Private Nursing Institution.

Probationer Haydon has been appointed Head Nurse in Astley Cooper in her place.

Nurse Graham has left the Hospital at the end of three years' training, and Probationer Candy has been appointed in her place.

A meeting will shortly be held of the Provisional Council of the Nurses' Recreation Society to make arrangements for the coming season.

Passim.

DR. STEVENSON has just made a most valuable addition to the small nucleus of a library which is being collected in the public health department. It consists of all the yearly reports of the Local Government Board, a series of the greatest value, and in this case the more so as some of the volumes are now unobtainable for love or money. The idea of having a special library for books on public health is a very good one and deserves to be encouraged, as the books are of no particular interest to the general body of men, but are of extreme value when collected, ready to hand, in their own special department.

Two well-known old Guy's men have passed away in the last fortnight. Dr. Bright, of Forest Hill, a popular and respected practitioner, died very suddenly on the 11th inst., and news has just reached us of the death of Dr. G. F. Farr, of Kennington Road. Dr. Farr was at Guy's in the fifties, but, always living in the immediate neighbourhood he never lost touch with the hospital. Younger generations of men will probably remember him better from his striking personal resemblance to his old friend Sir Samuel Wilks.

THE collecting boxes in the wards are a very good gauge of the interest shown in the hospital by the patients themselves, and are to some extent a measure of their gratitude. It is satisfactory to note that the sums collected in 1898 amount to £162, as compared with £110 in 1897, an increase of 45 per cent. The amounts vary considerably in different wards, ranging from 4s. 3d. in the Women's Surgery to £40 odd in Dorcas, a rather amusing contrast in feminine gratitude for diverse services.

THE number of patients sent to convalescent homes during the past twelve months is very large, being 771 for that period, an increase of 47 over the number sent in 1897; of these, 295 were sent to the Swanley Convalescent Home and 136 to Ascot, and other small numbers to various homes such as Bognor, Broadstairs, etc. These figures are exceedingly satisfactory in themselves, but there is one convalescent home in particular which is of especial service to Guy's. We refer to the splendid institution kept up by Miss Henry, at Worthing, entirely at her own expense, and devoted exclusively to the benefit in Guy's patients, 182 of whom were sent there of 1898. A home such as this is of incalculable benefit to the hospital, and it is pure charity applied to the best purpose.

THE Annual Residents' Dance has been fixed for the 9th of February, in the Court-room, and Mrs. Cosmo Bonsor has very kindly consented to act as hostess. The tickets will cost 8s. 6d. for men, and 6s. 6d. for ladies, and may be obtained on application to the Honorary Secretaries, Messrs. Brickdale, East, Fremantle or Starling.

THERE has been a fresh eruption of builders, housebreakers, and ward destroyers in the last week. The patients in Cornelius were moved over to old Mary ward on Tuesday, and since then the flooring has been pulled up, and the work of renovating begun. The quadrangle is being excavated just outside the ward door for the new staircase which is to be built in place of the old wooden one, and a lift is to be run up to the top of the surgical building, next the staircase. Also the forest trees which grow in tubs in the quadrangles are being transplanted to the ground itself, and pits are being dug in the asphalte for their reception, so the surgical buildings are full of life these days.

IN another column we publish an interesting letter from Surgeon McGregor, R.N., on the value of quinine in malaria and black water fever. Surgeon McGregor has used quinine in both diseases, and he adds his testimony to that of Dr. Crosse, in emphasizing the value of the drug, both as a remedy and a prophylactic. He states that the bluejackets all take quinine regularly, and are less subject to malaria and blackwater than the shore residents, and when they are attacked, the disease is much less virulent.

THE result of the match against East Sheen, who were rather poorly represented, was satisfactory. F. W. Sime was unable to turn out, and his place was taken by C. D. Pye-Smith. Our back, we think, stands too far behind the scrimmage, especially while playing with the wind. The three-quarters displayed very good combination which resulted in Rae scoring on three occasions. The half-backs are improved players, and make good openings: they should not be tackled with the ball. The forwards are a strong lot, and should hold their own against any hospital eight. They should get the ball oftener, and more smartly in the scrum, and ought never to allow an opponent to get away on the line-out. Against East Sheen, Mullins,

Manson, and Ayre-Smith showed up well. The match against Middlesex Hospital in the first round of the cup-tie, fixed for Tuesday next, has been scratched by Middlesex.

THE combined forces of the Nurses' Choral Society and the Students' Glee Club will give their third annual concert on Monday and Tuesday, February 13th and 14th, in the Governors' Court Room, and the proceeds, if any, will be given to the Nurses' Piano Fund. The programme will include Macfarren's May-Day and other instrumental and vocal music. Tickets, price 2s. 6d. each, may be obtained from any member of the committee, or from the Honorary Secretaries, Sister Christine and Mr. H. J. Starling.

May we remind our readers that the annual subscription—seven shillings and sixpence—for GUY'S HOSPITAL GAZETTE, became due on the 1st instant.

From the Gazette's Special Pathologist.

H. N. E., MARGATE.—Tubercle bacilli are present in the sputum in fair numbers.

H., RAMSGATE.—No tubercle bacilli could be found in the sputum.

G. E. H., RAMSGATE.—These hairs show no traces of any parasite of the nature of ring-worm. Although we have seen the condition before we do not know its cause.

H., REIGATE.—Tubercle bacilli are present in the sputum in fairly large numbers.

PATHOLOGIST.

Notice.

EXAMINING BOARD IN ENGLAND BY THE ROYAL COLLEGE OF PHYSICIANS OF LONDON AND THE ROYAL COLLEGE OF SURGEONS OF ENGLAND.

FIRST EXAMINATION.

PART II.—PRACTICAL PHARMACY.—Notice is hereby given that the Schedule of Drugs relating to the Examination in Practical Pharmacy has been recently revised by the Examining Board in England, in accordance with the new edition of the British Pharmacopœia, and that after the 1st May next, such revised Schedule of Drugs will be used by the Examiners at the Examination of all Candidates in Practical Pharmacy. The revised Schedule of Drugs may be obtained on application to the Secretary, Examination Hall, Victoria Embankment, London, W.C.

FREDERICK G. HALLETT, Secretary.

4th January, 1899.

Guy's Hospital Dental Society.

A MEETING of the above Society was held on Tuesday, December 13th, at 5 p.m. The President, Mr. Hopson, in the chair. The minutes of the previous meeting having been read and confirmed, the following casual communications were brought forward:—

Mr. DOWSETT brought forward the following cases. (*a*) Case of Dentigerous Cyst of lower left canine, showing models and skiagraph with tooth in situ, also tooth after extraction. (*b*) Case of Dental Cyst originating from lower left second premolar, and showed model, also tooth after extraction. (*c*) An upper left six year old molar, with roots unformed, extracted through a sinus just beneath outer canthus of left eye; the sinus being originally caused by necrosis of superior maxilla.

Mr. WHITE showed a partly developed lower central incisor which has been extracted owing to necrosis of lower jaw.

Mr. WILKES showed several good specimens of abnormalities of teeth.

Mr. ALDIS showed upper and lower models of a very close bite.

Mr. P. GREENWOOD showed a Radicular Odontome, class Cementoma, from upper jaw.

Mr. WARTSKI showed upper and lower models showing suppressed eruption of teeth.

The PRESIDENT then called on Mr. Garman for his paper on

EXTRACTIONS.

Mr. PRESIDENT AND GENTLEMEN,—It has been said that so soon as an individual becomes aware of the presence of an organ, whether through some pain or mere discomforture, that organ is in an unhealthy state, if not already the subject of disease. This is very generally true, unfortunately, of the organs of mastication. In fact, they are almost invariably well on the road to a diseased state before any real discomfort is experienced.

However this may be, there is certainly no operation productive of more successful results than that of an extraction brought to a happy issue. It becomes, therefore, a matter of considerable interest, and, indeed, of great importance, to dental surgeons to thoroughly appreciate, grasp, and make their own, the methods by which the difficulties, sooner or later to be faced in the field of extraction, may be attacked and successfully overcome.

The knowledge of the different instruments, the points possessed by each individual member of the series, and their use in actual practice, must be supplemented by an acquaintance with the anatomy involved, or likely to be so in case of accident. When to extract and when not, cases that are not straightforward, in other words difficult extractions, accidents to be guarded against and possibly treated, and the relation of operator to patient, are among some of the points I propose

dwelling according to the time at my disposal. Although forceps of a kind were in vogue as far back as 1830 they never attained much favour among the operators of the day. It is true that some little time later many were found advocating their utility and deprecating other methods; but even these were glad to have recourse to the key of Garangeot under cover of their own operating rooms.

Sir John Tomes, when he laid down the principles upon which the blades of the present forceps are modelled, revolutionized extraction. The old-fashioned key and punch, together with many other primitive contrivances, date their final dismissal from use to the efforts of Tomes.

Among some of the chief points enunciated by him I would lay stress on the following:—

The beaks of the forceps must be adapted to the neck, and part below this, of the tooth for which they are intended, and at the same time the upper portions should take the form of such a curve as to ensure their clearing the crown.

The pressure should be diffused over as large an area as possible, and only the best hard steel, reduced to somewhat of a spring temper, should be used in the construction.

This precaution is necessary, as in our patterns the tapering of the beaks is very fine. Compared with the American style, some of which, through the courtesy of Messrs. Ash & Son, I have here to show you, it will be seen that ours carry about half the amount of metal.

A point that cannot be overrated is the necessity for the edges being sharp. To root instruments, which should be of a lighter build, this applies with still greater force. The reason for this is evident. One of our aims in extraction is to injure the parts as little as possible. With this object in view the entrance of the blades between the root and alveolar process is desirable; nevertheless, in some instances, owing perhaps to malformation of the roots, exostosis, or excessive development of the alveolar process it becomes impossible to avoid penetrating the bony edge. Again, in an ideal case the passage of the forceps to embrace the roots should be by a clean cutting through of the fibrous attachments, either by a wriggling or pushing movement. It is well known in surgery that a clean cut, well defined wound, gets on better than one in which the tissues have been torn and lacerated, and possibly the bone crushed. Hence the importance of having one's instruments periodically seen to. The makers tell me that an Arkansas stone is what they use to restore the lost edge; in very bad cases they have to soften the blades. Perhaps, of all instruments, none receive less attention nowadays than the elevator; I think possibly this may be accounted for by a wholesome fear, arising from the knowledge of the anatomy of the parts. It is true that it is a dangerous weapon in ignorant hands, but if used in the method I propose attempting to describe, there should be no mistake. Supposing the offending organ to be a lower left wisdom, standing in front of the patient, always on the right hand side, with the left hand support the horizontal ramus by the thumb, placing the index finger upon the tooth in front of that to be operated on, the remaining disengaged fingers may be used to depress the tongue. Then holding the straight elevator firmly, with the first finger lying along the flat surface to within a quarter of an inch of the apex, apply it to the mesial side of the neck in a direction downwards, inwards and backwards, that will be from the buccal aspect. With a slight rotary movement push it well down between the socket and root, and then depress the long head of the lever, using the alveolar process as the fulcrum. It is often necessary to go down deeper a second and even a third time before the tooth is loosed from its socket. Should the adjacent tooth have to bear much of the strain, as it very often does, either directly or indirectly through the intervening septum of the alveolus, it is supported by the pressure from the finger, and anything like dangerous movement is at once recognised by the sense of touch. The finger along the shaft serves somewhat of the same purpose as the thumb in the use of the enamel chisel or straight hand-piece. By a slight retrogression, a greater amount of the shaft can be brought into actual use, as the burrowing or diving process advances, and at the same time any sudden slip due to the lack of resistance is at once checked.

I shall refer again to the use of this instrument under the consideration of difficult extractions, especially the curved variety, but beyond this I would only say that a blunt elevator is an abomination. To finish up with the instruments one might say that two-thirds of the success in extractions of to-day may be put down to their high excellency of finish and adaptability which they possess. It is through the instuments possessing these qualities that the detection of least and greatest resistance has been rendered possible. I say rendered possible advisedly because it requires much practice and patient care before maximum results are obtained in this direction. They have supplied a want in giving the operator something more, as it were, to go upon, rendering him capable of receiving impressions which prior to their perfection were not obtainable.

The next point, Mr. President and gentlemen, I wish to dwell upon is when to extract and when not. There are certain cases for which the treatment is pretty evident, others will depend upon the views and ability of the individual practitioner in charge of the case. Taking the temporary teeth first, extraction is indicated under three circumstances only.

When their remaining will evidently be to the detriment of their successor assuming a normal position.

In this connection it is important to recollect that a very slight force will be sufficient to effect this change, owing to the crowns having recently passed through an opening in the alveolar process, leaving the neck some amount of lateral movement until the further deposition of bone takes place. I think an acute alveolar abscess in a child would also warrant a tooth's removal, and lastly, those whose roots appear through the outer wall of the

alveolus and gum, irritating the surrounding mucous membrane. It is well to be on one's guard how one extracts these deciduous teeth in children suffering with necrosis after one of the exanthematous fevers. If in the involved portion, unless very loose, the premature wrenching away of the diseased bone is likely to occur, a state of things undesirable. The extent of the disease generally declares itself from the outset, ending in the loss of the temporary molars and their corresponding permanent teeth and alveoli. The child should be fed well, a mouth-wash such as permanganate of potash ordered; the sequestrum together with the contained teeth, can be removed by dressing forceps later on. The permanent series are not so easily got rid of.

Teeth with polypus of the pulp, and suppurating wisdoms in adults should be taken out, the second molar, if access to the former is not possible. In young people suffering with difficult eruption of these teeth, extraction of the six year old molar, combined with guillotining of the gum will generally be sufficient. If, however, the twelve year molar should prove to be the worse of the two, extract it instead. Cases of acute alveolar abscess, except those in connection with teeth whose roots have been satisfactorily filled, are best treated by extraction: also all septic roots or broken down teeth past filling, cases in which exostosis by elimination, has been diagnosed, likewise those of pyorrhœa alveolaris and epulis. The latter usually necessitates the sacrifice of one or more sound teeth for its proper removal. Loose and jagged members of the series, producing ulceration of the cheeks or tongue will be often treated best by removal.

Healthy roots in the front of the mouth should be retained in young people, as their presence saves the premature absorption of the alveolar process, and accompanying shrinkage of the gum. Other symptoms, such as periostitis, acute or chronic, pulpitis, and fractures, must be treated according to the individual merits of the case. I would only say, do the best for the patient under the existing circumstances. Before going on to the practical considerations of extractions, I would say, beware of removing sound teeth at the patient's request. People will say they are sure *that* is the tooth, pointing perhaps to a good lower bicuspid. These are often sufferers of neuralgia. Inspect the wisdoms, also any fillings, especially large metal ones, bearing in mind other causes of obscure pain, such as mercury, when pushed, exostosis, intrinsic calcification of the pulp, and the presence of gouty diathesis. Finally, respect your own opinion in preference to your patient's.

Salter, referring to an axiom of Mr. Cline's, says, "Every operation is performed quickly enough that is performed well." Although one would not like to strain the meaning of the words by accepting the axiom in too literal a sense, nevertheless I think it is one that all young operators would do well to remember.

Mr. President and gentlemen, I hope you will excuse me if I bore you with a few general rules at this part of my paper. My only excuse is the practical nature of the subject, and although a little actual practice may be, and is, worth any amount of reading, yet still I think that a time does come when for a man desirous of advancing to a higher pinnacle of manipulative skill in extraction, a little knowledge culled from the operating rooms of the profession is a great help in directing his efforts. Pay first attention to that blade which has to seize the most broken-down side of the organ. Thus, for a lower molar whose buccal side presents nothing but a bad cervical margin, make sure, above all else, that the blade gets outside this margin. If this is attained, the other may well be left to look after itself. Do the most difficult extractions first when practicable.

Under anæsthetics, other things being equal, begin with the lower jaw from behind forwards, as the bleeding will not unnecessarily obscure the field. It is much easier to change quickly from right to left, therefore get in the habit of working in this order. Every tooth or part of a tooth should be seen out of the mouth before proceeding to another. There is, however, one exception to this rule, the lower wisdoms, which are sometimes intimately attached to the gums on the posterior aspect after expulsion by the elevator from the sockets. These may be left even in gas cases, and the fibrous attachments cut through afterwards. Of course the responsibility of deciding whether the attachments are worthy of the name, and therefore strong enough, rests with the operator.

Supposing there exists any doubt whether a tooth will break, use root forceps. Let us suppose it is a lower molar. The anterior fang is generally the strongest and should be well-seized. If complete success does not attend this effort to dislodge the whole organ, the posterior root can by means of the curved elevator be pushed into the now vacant anterior socket. In gas cases this method is often very valuable as the second bicuspid, should it have to come out, may be treated in the same manner.

It will be observed that in this way there is always an empty socket between the point of the lever and the root to be dislodged, thus minimising the danger of disturbance to an innocent member of the series. The lower molars are apt to be very firmly embedded, more especially should they have been standing alone for some months, this latter remark applying to all teeth under similar circumstances, and within certain limits of age. The only thing to be done is to increase the force, steadily feeling one's way in different directions. Should prudence forbid further active measures the elevator may be tried as a start, or the roots may be split. Sending the patient away for a day is advocated by some, the theory being, that the inflammation set up by the previous attempt will have rendered the adhesive and cohesive forces exerted by the fibrous attachments and bone more yielding.

Upper molars, when Reed's are employed, should be seized by the palatine and anterior buccal. A slight twist outwards and forwards after the main outward

movement is very often successful in freeing the long palatine and anterior buccal root, which is sometimes tucked rather underneath the bicuspid. It is well to try taking upper wisdoms as directly outwards as possible, finally drawing them to the front, as it were, along the sulcus. In connection with the three upper molars there is an excellent instrument, which, through the kindness of our secretary, Mr. Palmer, I have here to show you. Being between a Reed and bayonet, it is particularly useful in doing the work of both these instruments, and with great success. I may say I have not tried it as yet, but have the word of others, including that of our worthy President. I believe it goes by the name of "the amateur's friend"—why, I cannot say. In attacking lower bicuspid roots, and all roots, in fact, one must dive, burrow, and feel one's way. Nothing is to be gained by closing the blades until satisfied of something to close upon. Otherwise it is more than likely that our best guide to what we want to obtain will be broken down—namely, the upper frail superficial portion of the root. It is better, on this account, to open the forceps too much than too little.

The use of a probe is often very desirable. A blunt-pointed one I prefer, as the gums do not get injured before the commencement of the operation. Any bleeding prior to this diminishes the chances of a brilliant success in the removal of roots. The mere fact of going down well for lower bicuspids very often causes them to jump out of their sockets. Few teeth are more treacherous, and certainly none require more careful watching in gas cases.

Occasionally canines, errupted high up out of the arch in the upper maxillary bone, cause some perplexity, very often not presenting so far as the neck of the tooth. Two parallel incisions in the gum either side of the long axis of the root may be made under these circumstances. I think it saves the gum being torn in driving up with the forceps, and as there is rarely any suppuration or exfoliation in these cases, (for the parts are generally healthy) the wound heals very rapidly.

Overlapping lower centrals and such like cases may be simplified by separation, either by tape or rubber; whilst instanding laterals which descend from the vault of the palate, should be rotated with downward traction. Roots hemmed in by overhanging crowns before and behind, may be attached by the straight elevator. One can easily understand that the dexterous manipulation of the elevator used either to prize the root out of the socket, or as a simple lever will help through with many such difficulties.

Any frail hollowed out roots such as are sometimes met with minus their artificial crowns, if filled with amalgam the day before, generally give no trouble. My last word on this subject is take care that in applying force for a tooth's dislodgement that it shall not be altogether disproportionate to the resistance.

And now I must hurry on to my last point. It is an old saying that "familiarity breeds contempt," one, the truth of which is from time to time I might say almost daily, brought before our notice, possibly by a terrible railway accident, some sad shipwreck, or loss of life in one of our London conflagrations. The starting point, I do not say of all, but some of these untoward results may be traced down to carelessness in some quarter or another. What I would wish to imply then is, how very important it is to keep in our minds the sense of our responsibility, doing our best for the patient and taking all necessary precautions against accidents, especially in gas cases. Finally, do not let the rush and wear of an exacting and busy life smother all feelings of sympathy for those who seek relief at our hands. Sympathy combined with firmness are indispensable adjuncts for those who would successfully manipulate the varying idiosyncrasies of disposition and character. And now I must thank you, Mr. President and gentlemen, for the very kind attention you have given to my humble effort. If this paper, poor as I fear it has been, should have no other effect than that of making some a little keener in the work of extraction, I shall feel that the time of this Society has not been altogether wasted at my hands. I would render my sincere thanks to the members of the Staff for their assistance, especially to Mr. Payne for putting at my disposal the valuable collection of antique instruments in the museum, and to those of my fellow students from whom I have received information and much kindness.

A discussion then followed in which Messrs. Payne, Clarke, H. Morris, Warlow, Bartlett, H. T. Campkin, Wilkes, Bennett, C. S. Morris, Stweni, and Wartski took part.

A vote of thanks was then given to Mr. Garman for his excellent paper, thus terminating the meeting.

Two Interesting Swellings of Lower Jaw.

I.—Case of Dental Cyst.

A. R., 32, female. Eleven months previously patient had pain in left side of her lower jaw. The patient says the bone began to swell from that time in the region of the second bicuspid tooth, and gradually increased in size. The patient never had any acute symptoms.

When seen there was a hard uniform swelling of lower jaw in region of second bicuspid, expanding the outer plate of the mandible, and filling up the buccal sulcus from the second molar behind to the first bicuspid in front. There was no egg-shell crackling over any part nor any softened area. The second bicuspid was very much tilted, so as to be lying along the alveolus, with its crown pointing forwards, and the first molar was missing, having been extracted fifteen years previously. Both the bicuspids and the second molar were living teeth, and neither of them showing the slightest sign of caries. A skiagraph was taken, and showed absence of any buried roots of the first molar from which a dental cyst might be arising, and also absence of any buried

supernumerary tooth which might be the cause of a dentigerous cyst.

A *dental cyst* arising from the second bicuspid was diagnosed.

Subsequently the patient was given gas, the second bicuspid removed, and its shallow socket found to be in direct continuity with the cyst cavity. Some of the alveolus was cut away, and the cyst wall scraped. The cavity was packed, and is now in process of granulation. The cyst contained a light yellow fluid, with abundance of cholesterine. The cyst wall was all bony, with a smooth epithelial lining. The tooth showed a well-marked, flattened facet on the side of the root pointing downwards, from which the cyst arose.

The point of great interest in this case is the illustration of a dental cyst arising from a tooth with a *living pulp*. In Mr. J. G. Turner's recent paper on Dental Cysts in the *B. D. A. Journal*, he states, on the evidence of a large number of cases, that they *invariably* arise from dead teeth or roots. The tooth in this case was obviously alive, and the cyst arose from its root, the facet being indicative. A persistent cyst from the first molar, which had been lost, is negatived by the probability that in that case, the root of the bicuspid would have been displaced in the opposite direction.

Its probable pathology seems to be a cyst arising in the alveolo-dental membrane, and originating from one of the epithelial remnants, or the "débris épithéliaux paradentaires," as described by Malassez, so commonly found microscopically in this membrane, and this stimulated to growth, by some irritant, but not through the root canal.

II.—CASE OF DENTIGEROUS CYST.
(Follicular Odontome.)

L. D., 19, male. The patient first noticed two years ago that his lower jaw, just to the left of the middle line, was beginning to swell. There was no pain at the time. It gradually increased for some months, and then suddenly became very painful and more swollen, and shortly pointed on the gum, discharging a quantity of pus, leaving a sinus which has discharged at intervals ever since. When at its height, the patient went to a dentist, who extracted the first lower left bicuspid, which, however, proved to be a perfectly sound, living and healthy tooth.

On examination, there was a hard, uniform swelling of the mandible, to the left of the symphysis, apparent externally, and filling up the buccal sulcus in the canine region, the lingual aspect of the jaw being normal. The left canine and first bicuspid were missing, and the patient stated that he never remembered having had a canine tooth in that region. The central and lateral were spaced. A sinus was seen in the sulcus just to the left of the lateral. On probing the sinus, a cavity was found in the bone, and a hard smooth substance projecting from its floor that "struck" like enamel.

Dentigerous cyst of lower left canine was diagnosed. A skiagraph was taken, and the diagnosis confirmed, the canine tooth being plainly seen lying transversely low down in the jaw, and a lighter area around, indicating the cyst. The process of reproduction has rendered the tooth much less obvious than in the negative. One might ask the differentiation here between a dentigerous cyst and a retained canine. The fact that the crown of the tooth projected directly into the cyst was strong evidence in favour of the former.

Patient was taken in, anæsthetised, the outer wall of the cyst chipped away, and the tooth removed, the cyst cavity being scraped and packed. The tooth proved to be an exceedingly well-formed one, the root being straight and complete, with a normally sized apical foramen. The whole root was embedded in the cyst wall.

The points of interest in connection with this case are:—

(i.) The illustration of the aid of skiagraphy in such affections, which is indeed proving to be of very great value in dental surgery.

(ii.) The position of the cyst, this form of odontome being much more common in the bicuspid and molar regions.

(iii.) The well-formed condition of the tooth, the roots of these teeth being generally misshapen.

E. B. D.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Mr. Landon Returns Thanks.

DEAR SIR,—I should like to thank all those who so kindly helped us to make the Children's Tea the great success it was. The great interest taken in the scheme, and the willing way in which all connected with the Hospital both subscribed themselves and collected funds and clothing, has raised the hope that the affair may be made an annual one. As regards the funds raised, I should like to mention one pleasing incident, viz., the working men employed about the Hospital collected among themselves over £2. To those Nurses who came and helped us on the day, our thanks are especially due,

for it was mainly due to their kindly help that the whole affair passed off so well as it did. The greatest part of the work fell upon the District Nurses, and to them is due the greatest praise. Our thanks are due also to the St. Olave's Nursing Association and the Charterhouse Mission for collecting children. To Mr. Lafone we were indebted for a present of 100 lbs. of tea. To Messrs. Huntley & Palmer for a barrel (121 lbs.) of biscuits. To Messrs. Imhof and Mukle for a Polyphon, which I think most of the wards received with pleasure. Where so many gave it is hard to make distinction, and so I think it best to say that we sincerely thank all for their great kindness, and express the hope that if the Tea becomes an annual affair, that as they have helped in the past so may they continue to help in the future. The number of children who came was about 550, nearly 90 more than last year.

Before closing I should like to offer my own sincere thanks to the Committee for the way in which they have helped, and especially to Sister Christine who as Out-Patient Sister worked so hard and untiringly. To you, Sir, the thanks of all are due for the kind way in which you have so often appealed on our behalf.—I remain, yours faithfully,

T. LANDON.

Errata.

DEAR SIR,—I beg to point out a few errors that have crept into my paper on "Inlays" published in the GAZETTE, December 3rd, and hope you will find it possible to have them corrected, as they somewhat alter the sense. The chief are:—

"filling"	instead of	"fitting"	...	col. 1	line 35
"to"	"	"in"	...	" 3	" 10
"bar"	"	"bur"	...	" 4	" 40
"string"	"	"truing"	...	" 4	" 44
"flat groove"	"	"flat sided groove"		" 4	last line
"lina"	"	"lined"	...	" 6	line 15
"first"	"	"pivot"	...	" 7	" 20
"glasses"	"	"glass is"	...	" 7	" 30

and continuing the sentence, "are" should be "and is" on the next line. The paper is on page 536. Thanking you in anticipation.—I remain, yours sincerely,

J. H. WILKES.

Guy's Hospital, December 19th, 1898.

The Treatment of Malaria and Blackwater Fever.

DEAR SIR,—In your issue of October 8th I have read with much interest the able address given by Dr. Crosse at the opening meeting of the Physical Society, on "The Treatment of Malaria and Blackwater Fever," and should like to add my testimony of the value of Quinine in the treatment of these diseases. I have now had a fair amount of experience of malaria in the West Indies, in West Africa, and here on the Zambesi and Shire Rivers, and I have no hesitation in saying that I consider Quinine, in some form, is absolutely essential for the cure of remittent and intermittent fever, and in cases where, from persistent vomiting, it cannot be retained, it must be administered hypodermically. Of the so-called Blackwater Fever, which I regard as a pernicious form of malarial fever, I have had three cases under my care, and in all of them Quinine was given in doses of 45–60 grains in twenty-four hours throughout the illness, and all recovered. And not only is Quinine administered during an actual attack of fever, but the bluejackets here take five grains of Quinine night and morning for several months at a time, and Blackwater Fever is rare amongst them, although they suffer from the ordinary remittent and intermittent types, but in a much less aggravated form than occurs amongst residents on shore. This I attribute, partly to the fact that although Quinine cannot be regarded as an absolute preventive, it undoubtedly diminishes the severity of attacks, and partly because residents on shore drink the river water without, in a great many cases, even taking the trouble to filter it, and much less to boil it: and this water I have proved, both by chemical and microscopical examination to be a very undesirable form of drinking water. On board, here, our men are not allowed to drink any but condensed water, but, of course, it is impossible to prevent them from occasionally getting some of the river water when they go ashore, and I feel certain that if we could so restrict them our returns of malarial fevers would be still smaller than they are. I do not deny that they are not so much exposed to the sun and rain as are many people who have to earn their livelihood on shore, but I do wish to emphasise the fact that in my opinion bad drinking water and the absence of regular doses of Quinine will account for the much more severe types of fever occurring on shore. In conclusion, I would wish to point out what a splendid field for the investigation of malaria exists out here in British Central Africa, and that a Guy's man who has done plenty of bacteriological work would be a very fit and proper person to clear up some of the mysteries at present attached to this scourge.—Faithfully yours,

G. McGREGOR,
H.M.S. "Mosquito," Surgeon, R.N.
Zambesi River, E. Africa, December 1st, 1898.

Papers by Guy's Men.

A Case of Phthisis with Peculiar Cardiac Physical Signs. By W. Hale White, M.D. Lond.—*Lancet*, 19th November.

The Osseous System in the Insane. By J. F. Briscoe, M.R.C.S., F.R.G.S.—*British Medical Journal*, 3rd December.

A Clinical Lecture on a Case of Gall-stones in the Common Duct causing Simple Infective Cholangitis. By W. Hale White, M.D., F.R.C.P. Lond.—*Lancet*, 3rd December.

Sport.

Rugby Football.

GUY'S v. OLD LEYSIANS.

This match was played at the Crystal Palace on January 7th, and resulted in a win for the Old Leysians by 2 tries (6 points) to nil. The ground was rather heavy on account of the recent wet weather, and to make matters worse, rain began to fall before the game had been in progress many minutes. Guy's were not so well represented as when the two teams met earlier in the season, both halves being away, and one or two of the regular forwards.

The Old Leysians kicked off, and Rae returned into touch, and a good run by Sime gained ground for Guy's. The Old Leysians' forwards brought the ball into Guy's territory, Pye-Smith relieving by a good kick into touch. Some good play by the Old Leysians' backs put the Hospital on the defensive; a free kick to Guy's, and a rush by the forwards, transferred the play to neutral territory. The home side, however, getting the upper hand, the ball was returned to the visitors' twenty-five. Evans obtaining the ball kicked into touch. At this stage of the game Pye-Smith had to retire for a time, owing to an injury to his leg, Cutler taking his place at half-back. A series of scrums followed, from one of which the Old Leysians' backs obtained the ball, and by a good bout of passing, Guy's were again pressed. Two or three attempts to score on the part of the home three-quarter line were frustrated by the keen tackling of our backs. Sime made several useful runs, and aided by some good play by the forwards, the game was taken into the home quarter. The Old Leysians soon brought the ball back, and a dangerous rush was stopped by Wilks. Rae made a good run carrying the ball to mid-field. Good passing between Pye-Smith, Louisson and Sime here followed, but the Old Leysian back division retaliated. Evans was called upon to clear his line, which he did by a good kick into touch near the half-way flag. The whistle sounded for half-time, neither side having scored.

Guy's started well in the second half; the forwards by some good rushes, in which Manson was conspicuous, put the home side on the defence. Some give-and-take play followed, Guy's backs indulging in a pretty round of passing. The Old Leysians eventually getting the upper hand, closely following up a punt, Evans was unable to get his kick in; a scrum followed close to Guy's line. Lloyd obtained the ball, and cleverly bluffing his opposing half, and one or two of the Guy's three-quarters, gained a try; the kick at goal did not add to the score. The home team again pressed, Hilton put in a good run and passed to Rae, the latter being forced into touch at half-way. The Old Leysians gradually worked the ball back into Guy's quarter. Owing to some faulty lining out on the part of Guy's forwards, one of the Leysians' forwards obtained the ball and dashed over the line, scoring their second try. The kick was a failure. From this out the Old Leysians pressed, their forwards getting the ball well in the scrums, the halves were able to give the three-quarters plenty of opportunities. Manson dribbled splendidly, carrying the ball well past the half-way line. The match was brought to a close, resulting in a victory for our opponents by 2 tries to nil. Team:—

GUY'S.—G. Evans (back); F. L. Rae, F. W. Sime, C. T. Hilton and J. H. Wilkes (three-quarter backs); C. Louisson and C. D. Pye-Smith (half-backs); R. C. Mullins, D. H. Trail, H. A. Cutler, P. T. Manson, A. H. Wall, R. C. Lawry, K. V. Trubshaw and G. Shorland (forwards).

GUY'S v. CROYDON.

Owing to Sime's absence, pending examinations, and injuries sustained, the hospital team which met Croydon in the return match at Honor Oak Park on Saturday, 14th January, did not, on paper, appear a strong one; and a second defeat was expected by most of their supporters. All departments, however, played with rare dash, and the team must be congratulated on the by no means unsatisfactory result of an interesting game, which was witnessed by quite a large, and certainly an enthusiastic crowd.

Losing the toss, Mullins kicked off against what wind there was; Yeld muffed the return from Evans, and play settled down in the Croydon twenty-five. A good forward rush headed by Marples and O'Dowda, took the ball back to half-way, but the hospital forwards, securing the ball in the scrum, and wheeling in good style, again attacked; Moore eventually punting into touch. Evans was slow in fielding the ball, and a misjudged speculation on the part of Rae almost let Croydon in; but Mullins saved in the nick of time, and, after several hotly contested scrums on our goal-line, Jackson relieved. Good passing between Hilton and Pye-Smith transferred play to the visitors' end, but their forwards again got away, and faulty passing alone frustrated the efforts of their three-quarters. A kick from Moore necessitated a touch down, and this was repeated when Cocq dribbled over the line, half-time arriving without score on either side.

Pye-Smith's return to the kick-off was a good one, but Moore ran well down the touch-line, and Croydon again attacked, good kicking by Evans on more than one occasion relieving the pressure. Cocq soon after got away, and Howard-Smith dribbled over the line, but Rae touched down. For the second Saturday in succession one of the forwards was in front on kicking out, and a scrum took place in front of goal. Wall was penalised for offside play, and O'Dowda made a good attempt which just fell short. Hilton, by a good run, and kick into touch, transferred play to the half-way flag, and from this point to the end of the game the visitors were never dangerous. Passing between Hilton, Pye-Smith and Rae gave the last named an opportunity, but he was forced into touch a few yards from the goal-line. The hospital pack attacked for some time, and free kicks were

taken by Evans and Hilton, but without success. Another piece of combined play by our three-quarters was spoiled by faulty passing, due, no doubt, to the greasy condition of the ball, and when time was called neither side had scored.

REMARKS.—The forwards, to a man, played a sound game after the first ten minutes, when they were inclined to pack unevenly. They secured the ball in the scrum, wheeled, and tackled in great style; and being set a good example by Mullins, saved by dropping on the ball instead of trying to pick it up as has been their custom lately. There appeared to be far more shove in the scrum, and our pack was decidedly the fresher at the end of a trying game. Mullins, Ayre-Smith and Wall were, perhaps, the most conspicuous. The halves both played well, M. C. Wetherell especially getting the ball away well from the scrum, while Jackson's defence was good. Pye-Smith showed much improved form, tackling and saving well, while Hilton's kicking was well judged. Wilkes was inclined to deliver and take his passes erratically, but this was excusable considering the condition of the ball. Evans kicked very well, but is still inclined to be slow in fielding. Team :—

GUY'S.—G. Evans (back); J. H. Wilkes, C. D. Pye-Smith, C. T. Hilton and F. L. Rae (three-quarter backs); M. C. Wetherell and F. D. S. Jackson (half-backs); R. C. Mullins, A. Ayre-Smith, H. French, P. T. Manson, A. H. E. Wall, R. C. Lawry, K. V. Trubshaw and G. Shorland (forwards). Referee: Mr. E. V. Gardiner.

GUY'S v. EAST SHEEN.

The match with East Sheen on Wednesday, January 18th, was as it usually is with a scratch team, of a somewhat scrambling order. On this occasion, however, there was considerable excuse for it as a high wind was blowing obliquely across the ground, and the turf itself was in a very sodden and heavy condition. In the light of the approaching cup ties the game presented several features of interest. Guy's were at full strength barring the absence of Sime, but East Sheen were not so strongly represented as when they met and defeated the hospital before Christmas. At the start, Guy's playing against the wind, took some time to settle down, and from start to finish there was no really tight scrummaging. The opposing pack resorted (and with justification) to loose "spoiling" tactics. For the first ten minutes Guy's had a trifle the worst of the exchanges, but after that the game was all in the hospital's favour. Pye-Smith was the first to score, receiving the ball from O'Brien after Wetherell had made a good opening, but no goal resulted. The visiting back here had to retire from the game with a crocked ankle, and at half time the full side was made up by a substitute. Just previous to the whistle sounding Rae got in on the extreme right after a characteristic run along the touch line, and being badly missed by the full-back. The kick, dead against the wind, fell short.

After change of ends the game was in the Sheen half of the ground for practically the whole of the thirty minutes. Rae scored twice—on each occasion after some good passing by the three-quarters, and the first try O'Brien converted by means of an excellent kick from close to the touch-line. Jackson was conspicuous for a splendid run from near the half-way line, but unfortunately fell when just on the point of grounding the ball between the posts, and East Sheen managed to avert the disaster. Thomas from a loose scrum scored a disallowed try—why disallowed no one seemed to know—a five yards scrum being ordered. The final result thus read :—

Guy's	...	...	1 goal, 3 tries.
East Sheen	...	...	nil.

GUY'S.—G. Evans (back); C. T. Hilton, C. D. Pye-Smith, A. O'Brien and F. L. Rae (three-quarter backs); F. D. S. Jackson and M. C. Wetherell (half-backs); R. C. Mullins, T. P. Thomas, D. H. Trail, A. Ayre-Smith, H. A. Cutler, P. T. Manson, K. V. Trubshaw and A. H. E. Wall (forwards). Referee: Mr. A. H. Hall.

REMARKS.—Evans was quite sound at full-back. The three-quarters were all good; Hilton had least to do. The passes considering the state of the ball were exceptionally well taken, but several of them could have been more accurate, and therefore much less difficult for the receiver than was actually the case. The halves played a good combined game, but at times they were rather slow at getting the ball away from the scrum, thus giving their opponents chances of swamping them. They must not wait until the ball is absolutely clear of the back row before passing it out. The forwards played a good game, but as before mentioned, there was not much close play, and in consequence they hardly showed up as prominently as on the previous Saturday. Improvement could well be shown at the line-out, and combined dribbling had not a very conspicuous place in the programme, though on such a day it certainly should have had. However, reliance can well be placed on them to show up well next Tuesday, and if they do the result is assured.

Association Football.

GUY'S v. CROYDON PARK.

This match was played at Honor Oak Park, on Jan. 7th, in dreary weather, the ground being very muddy. Croydon Park, who have never yet beaten Guy's, turned up with a strong team, determined to do so this year if possible. At first it appeared as if they would accomplish the feat, as they soon scored, and played a much faster game than we did. But owing to the great exertions of Wiltshire we managed to get level with our opponents. Dent and Newton each scored a goal, Guy's thus winning a rather disappointing game by four goals to three. Walker at half played a splendid game, and did much towards the final result. We should like to remind the men that the Inter-Hospital Cup-ties come off soon, and if we are to have a good look in for the cup, the men must make a point of being fit. Team :—

F. M. V. Smith (goal); W. M. Robson, N. P. Shepherd (backs); R. W. B. Hall, F. E. Walker, J. Matthews

(half-backs); F. R. Manser, H. L. Dent, H. P. Wiltshire, L. Norton, W. O. Roberts (forwards).

GUY'S v. WEYBRIDGE.

Played at Weybridge, on January 14th, and won by the home side, four to two. Guy's played against wind and sun, and from the kick-off went through brilliantly, Norton failing, however, to score when quite clear. Soon after the start Guy's had the game entirely in their own hands and in the absence of one of the Weybridge side pressed continuously, Wiltshire eventually scoring (1–0). After so brilliant a start the result was disappointing, Weybridge equalized almost immediately, a muddle between a back and goal-keeper resulting in an easy goal being scored (1–1). Weybridge soon got the better of the game and for the rest of the first half did most of the pressing, the outside left continually centering the ball, and half-time arrived with the score 2–1. Playing up better Guy's pressed a little, the game became very open, but Weybridge scored again through muddling on the part of the back division (3–1). Dent broke away from mid-field and scored, (3–2)—the most brilliant individual feat of the day—but Weybridge had decidedly the upper hand and scored again from a deplorable muddle in front of goal (4–2). The forwards in the first quarter of an hour were brilliant and dashing, the shooting was bad throughout, and the last quarter of an hour was a poor display indeed. The backs were quite disorganised, and muddled each other dreadfully. Hall did not mark his outside, which resulted in his being well fed and repeatedly breaking through. Longhurst's game was dashing, but scarcely safe. German played well. Smith stopped some very good shots and cleared once or twice very well, but must make up his mind to call and act at once. Wiltshire was the best of the forwards. The game was rather straggling, but never very slow. The outsides appear to have no dash and never to attempt to break away and centre at once, two points essential to goal-scoring. Team:—

GUY'S.—F. M. V. Smith (goal); N. P. Shepherd, E. A. Longhurst (backs); R. W. B. Hall (capt.), H. B. German, J. N. Brydone (halves); H. L. Dent, H. R. Manser, H. P. Wiltshire, L. Norton, P. A. Peall (forwards).

United Hospitals' Hare and Hounds.

FIXTURES, 1899.

Date.	Description of Run.	Place.
Jan. 7	Ordinary Run	Chingford.
„ 14	Paper-chase...	Chingford.
„ 21	Ordinary Run	Chingford.
„ 28	Social Run with Blackheath Har.	Chingford.
Feb. 4	Match *v.* Lea Harriers	Chingford.
„ 11	Match *v.* Oxford	Oxford.
„ 18	Paper-chase...	Chingford.
„ 25	Inter-Hospital Challenge Cup, Long Distance Handicap ...	Chingford.
Mar. 4	Ordinary Run	Chingford.
„ 11	Closing Run...	Chingford.

Guy's Hospital Bicycle Club.

At the annual general meeting of the above flourishing club held on Tuesday, December 13th, Mr. Golding-Bird in the chair, A. M. Gabriel was elected Vice-Captain to succeed H. S. Turner; Messrs. Wilkes, Ker, May and Greenwood were voted on the Committee, *vice* Messrs. Brook, Hatfield, Gabriel and Simpson; Hugh T. Campkin was elected to succeed W. P. Ker (resigned) as Honorary Secretary and Treasurer.

Mr. Golding-Bird, amid much enthusiasm, offered a Cup to be competed for annually by members of the Club. A special meeting will be shortly held to determine the limits of the competition.

Fixture cards will soon be out containing a list of runs for the ensuing season.

HUGH T. CAMPKIN, Hon. Sec.

Appointments.

CIVIL.

PAKES, WALTER C. C., D.P.H. Cambridge, has been appointed Professor of Hygiene in the Bedford College for Women.

MILITARY.

MAJOR E. S. MARDER, R.A.M.C., is posted to Portsmouth on return from Egypt.

The undermentioned gentlemen are appointed Surgeon-Lieutenants:—ARTHUR E. LARKING, M.D., 1st Volunteer Battalion the Buffs (East Kent Regiment); WILLIAM G. BRETT, 1st Volunteer Battalion the Dorsetshire Regiment.

Births.

LUCAS.—On January 9th, at Broadway House, Tooting, the wife of Claude R. Lucas, M.R.C.S., L.R.C.P., of a son.

WORNUM.—On January 8th, at Belsize Park, N.W., the wife of George Porter Wornum, M.R.C.S., of a daughter.

Marriage.

TAYLOR—PEECH.—On January 7th, at Holy Trinity Church, Roehampton, S.W., Alfred Ernest Taylor, M.B., B.S. Lond., F.R.C.S. Eng., of Lancaster Gate, W., to Mary Emma, eldest daughter of William Peech, of Fern Bank, Roehampton Park, S.W.

Deaths.

BRIGHT.—On January 11th, suddenly, at Alvaston, Forest Hill, John Meaburn Bright, M.D., M.R.C.S., Vice-President, British Medical Benevolent Society, aged 65.

FARR.—On January 11th, suddenly, at Penrhyn Lodge, Cambridge Park, Twickenham, George Frederick Farr, L.R.C.P., M.R.C.S., in his 67th year.

ED.—H. L. E.

Contents.

	PAGE
ALTERATIONS OF WEIGHT BY DIET: Clinical Lecture by Dr. Hale White	41–48
HOSPITAL NEWS...	48–49
NOTES FROM THE OPHTHALMIC OUT-PATIENT DEPARTMENT	50–52
SOME CASES OF SCARLET FEVER	52–53
GUY'S HOSPITAL DEBATING SOCIETY	53–54
GUY'S HOSPITAL LONDON UNIVERSITY CLUB	54
PASSIM	55–56
FROM THE GAZETTE'S SPECIAL PATHOLOGIST	56
PNEUMOTHORAX: Clinical Lecture by Dr. G. Newton Pitt ...	57–64
OBITUARY: Robert Fenton Macdonald	64
ROYAL COLLEGE OF SURGEONS OF ENGLAND	64
CHRISTMAS TEST EXAMINATIONS	64–65
SPORT: Football—Rugby: Guy's v. Rosslyn Park; Guy's "A" v. Redhill and Reigate; Guy's 3rd XV. v. Southwark "A." Association—Guy's v. Ipswich; Guy's v. Charing Cross Hospital—Inter-Hospital Challenge Cup (2nd Round); Guy's 2nd XI. v. Eversleigh; Guy's Hospital Lawn Tennis Club; Guy's Hospital Chess Club	66–68

Calendar of Coming Events.

Feb., 1899.

Sat. 4.—Messrs. Golding-Bird and Dunn's take-in; Drs. A. M. Barron and E. Stott; Cl., L. E. C. Handson.
1.15, Clinical lecture by Dr. Pitt.
G.H.R.F.C. I., Catford Bridge, home.
G.H.A.F.C. I., Ewell, home.
II., Ewell, away.
G.H.P.P.S., Pathological Meeting.

Mon. 6.—1.30, Clinical lecture by Mr. Lucas.

Wed. 8.—Messrs. Howse and Jacobson's take-in; Drs. H. B. Carr and A. McCabe Dallas; Cl., R. Balderston.
G.H.A.F.C. I., R.M.A., away.
II., St. Mary's Hospital, home.

Thur. 9.—G.H.M.P.U., Missionary Meeting.

Sat. 11.—1.15, Clinical lecture by Dr. Pitt.
G.H.R.F.C. I., Kensington, away.
II., Kensington, home.

Mon. 13.—1.30, Clinical lecture by Mr. Lucas.

Tu. 14.—Meeting of the Dental Society at 4.30 p.m.
Dental Society's Dinner at 6.30 p.m.

Wed. 15.—Messrs. Davies-Colley and Symonds' take-in; Drs. W. H. Brailey and E. A. Miller; Cl., W. H. M. Telling.
G.H.A.F.C., I., Royal Vet. Col., home.

Thur. 16.—G.H.M.P.U., Devotional Meeting.

Sat. 18.—1.15, Clinical lecture by Dr. Taylor.
G.H.R.F.C. I., Lennox, home.
II., Lennox, away.
G.H.A.F.C., I., Old Cranleighans, home.
II., Old Cranleighans, away.
G.H.P.P.S., "Treatment of Fractures," by C. T. Hilton.

Guy's Hospital Gazette,

FEBRUARY 4, 1899.

Alterations of Weight by Diet.

CLINICAL LECTURE BY DR. HALE WHITE.

December 10th, 1898.

GENTLEMEN,—From time to time I try to give you a clinical lecture on cases that you rarely or never see in hospital practice, and I think it is a good plan, for it is the only way to prepare you to meet difficulties that you will encounter after you have left Guy's. For this reason, last winter, I gave a lecture on morphomania, and to-day I propose that we should discuss the treatment of those persons who seek advice because they are far above the average weight for their height, and in whom the extra weight is due to an excess of fat, and those who are wasted so that their weight is far below the average for their height, who have no organic disease but who are weak and feeble.

It is of the utmost importance you should bear in mind that the limits of weight in health are very great. We all of us know very heavy and very light men who are perfectly healthy. One of the healthiest of my friends is of good height, always looks excessively thin, is always of a very light weight, but always has an excellent appetite. Then, again, some old men are excessively thin but perfectly healthy. Indeed it is probable that the weight of healthy adult men varies within ten stone, or perhaps a little more. However, now to the subject of our lecture, and we will first of all take the abnormally fat people who come to us asking us to reduce their weight.

The most celebrated dietetic treatment for these persons is that known as the Banting method, from the fact that Mr. Banting, who dieted himself on the recommendation of his doctor, W. Harvey, published an account of it. By restricting himself to it he reduced his weight from 14st. 6lbs. to 11st. 2lbs. in about a year. The diet consisted of: Breakfast, 9 a.m.—Five or six ounces of either beef, mutton, kidneys, boiled fish, bacon, or cold meat of any kind, except pork or veal, a large cup of coffee or tea without milk or sugar, a little biscuit, or one ounce of dry toast. Dinner at 2 p.m.—Five or six ounces of any fish, except salmon, herrings, or eels, or of any meat except pork or veal, any vegetable except potato, parsnips, beetroot, turnip or carrot, one ounce of dry toast, fruit, not sweetened, any kind of poultry or game, and two or three glasses of good claret, sherry, or madeira; champagne, port or beer being forbidden. Tea at 6 p.m.—Two or three ounces of cooked fruit, a rusk or two, and a cup of tea

without milk or sugar. Supper at 9 p.m. Three or four ounces of meat or fish similar to dinner, with a glass or two of claret or sherry and water. Some of the good that this did Banting was due to the fact that before dieting himself he had been over-eating himself. Many other diets, having for their object the reduction of weight, have been published, such as those of Brillat-Savarin, Moleschott, Cantani, Ebstein, Towers-Smith and others, but there is no need to weary you with details of them. I only give you Banting's in detail because it is so much talked about. It is a bad thing for you to have definite diets placed before you, for then you are liable to apply the same diet unthinkingly to different patients, forgetting that we vary enormously in the amount and kind of food we take. What is one man's food is another man's poison. In dealing with the dietetics of disease you must know the general principles which should guide you, but if you are to be thinking, intelligent physicians, you must adapt the diet—when the condition requires any modification of diet—to the particular tastes and habits of each individual patient.

If you are going to try and reduce a fat man's weight, the principle to guide you is the physiological fact which you already know, that although fat may be derived from proteid, yet proteid leads to the destruction of the fat already in the body. From this it follows that if you give sufficient proteid and considerably diminish the amount of carbohydrates and hydrocarbons in an ordinary diet, you can cause such a destruction of body fat that the weight of the body will decrease, and the diets recommended by the authors whose names I have given you agree in this, that they all contain more proteid and less carbohydrates and hydrocarbons than ordinary diet. Towers-Smith was the most thorough, for when his patients were on the most strict diet they were taking for breakfast one pound of rump steak without fat; lunch, another pound of rump steak; dinner, one pound of grilled cod and one pound of rump steak. They drank at intervals during the twenty-four hours a gallon of warm water, and the last thing at night had an ounce of whisky in some water. He himself on this diet lost eighteen pounds in fourteen days. Many of you have been able to watch the following case, which has recently been in Stephen ward.

James W., æt. 53, came into the hospital on account of giddiness; this, however, proved to be of little importance, and he complained much of his stoutness, saying he would like to be dieted with the object of reducing it. The dieting was begun on July 22nd; he then weighed 15st. 5lbs., and was obviously very fat. He was put upon the following diet:—

Breakfast.—1lb. lean beef steak, 1 pint of weak tea without milk.

Dinner.—½lb. of cod, ½lb. lean beef steak, 1 pint of water, and a little green vegetable.

Supper.—1lb. lean beef steak, 1 pint of water.

He did not find this diet very pleasant, but he managed it without any difficulty. He had no medicine except a mild aperient occasionally.

On July 29th, he weighed 15st. ½lb., having therefore lost 4½lbs. in a week. On August 5th, his weight was 14st. 11lbs., a loss of 3½lbs. in the week. On August 12th, his weight was 14st. 9½lbs. a loss of 1½lbs. in a week. He now went out of the hospital of his own accord, overjoyed with the result of the treatment, for he said he had never felt better in his life. It will be seen that his total loss of weight was 9½lbs. in three weeks.

Here is another case I have been able to watch. A gentleman, 5ft. 8in. in height, weighing 15st. 4lbs., and obviously very fat, for four weeks took the same diet as the hospital patient. During this time his weight descended to 14st. 3lbs. on May 19th, 1897. He then took to having steak for breakfast; for his other meals any lean meat, and with all meals a little dry toast. On August 13th, 1897, he was 13st. 4lbs.; on July 30th, 1898, 12st. 4lbs. He now takes for breakfast a cup of coffee, a small piece of lean steak, and dry toast.; for lunch, a cup of coffee, three or four mutton or beef sandwiches without butter, and dry toast; for dinner, fish or soup, a piece of lean steak, green vegetables, toast, stewed fruit, a glass of claret, and occasionally a little pastry. This patient is so pleased with his reduction in weight that the difficulty is to prevent him from reducing his weight too much. I cannot persuade him to take more than the above, and he does not drink enough fluid.

The next case I will give you is that of a very short stout lady, who weighed 13st. 1lb., was very fat, and found much difficulty in getting about. She, for seven weeks, every day took two pounds of lean steak with a little toast, and no other food. She drank fairly of tea and water. In the seven weeks she lost 16lbs. She has now for over a year taken meat thrice a day, eaten very sparsely, if at all, of the "sweets course," and has very much restricted her fats and carbohydrates. Both the last two patients express themselves as feeling quite different people since they lost in weight; they are very

pleased with the result and their general health is excellent.

These three cases are quite sufficient to prove to you that it is easy by alterations in diet to reduce the body weight, but I beg you will not go away with the idea that you may do it recklessly. In the first place you must always satisfy yourself that the excess of fat is harmful. Do remember the wide variations in every part of the human body. One man is 5ft. 4in., another 6ft. 4in., both may be healthy. One is fat, the other is lean, both may be healthy. Whatever part of the body you are examining always, if you find a deviation from the usual standard, say to yourself, Is this deviation sufficient to be called pathological? Can this disc be so red and yet healthy; Can such a want of symmetry in action between the two sides of the mouth be of no pathological significance? Can these two pupils be so unequal and yet the patient not have some disease of his third or cervical sympathetic nerves? So be sure that the large amount of fat on your patient is unhealthy for that particular patient, and the best way to determine that question is to see whether the weight of fat he carries about incommodes him. If it does he complains that he cannot walk about as he did, going upstairs makes him short of breath and he is easily fatigued. You should then examine him from head to foot to make out whether he has any other cause for his breathlessness, such as disease of the heart, lungs or kidneys, anæmia, diabetes, and so forth. Even if you find no such cause, you must by no means at once conclude that you may diet him. Old people do not bear the treatment at all well. I know the case of a very old lady in whom the attempt was made to reduce her fat by increasing the proteid in her diet. She did not improve, and not long after the treatment began she slowly sank and died for no perceptible reason. I, the other day, refused to have anything to do with the dieting of a fat old lady who had been very fat most of her life. To suddenly alter the whole metabolism of the body as you do by giving an almost entirely proteid diet is more than you can expect aged tissues to stand, and you will hardly be surprised to hear that Sir William Broadbent has seen serious cardiac dilatation result from indiscriminate use of diets for obesity. Therefore you must only treat those whose organs are all sound, in whom it is clear that the excess of fat is harmful, and who have not reached old age. Having got such a patient there is no hocus pocus about the diet. You must give them very little carbohydrate and hydrocarbon and plenty of proteid. Therefore you feed them on lean steak and cod because there is less fat in these two forms of flesh than in any other ordinary article of diet. The other forms of flesh, even when lean, contain a considerable quantity of fat in between the muscular fibres. Supposing your patient to be a big man with sound organs he can often begin, as our hospital patient did, with 1lb. of lean beef steak for breakfast, ½lb. of cod and ½lb. of lean beef steak for dinner, and 1lb. of lean beef steak for supper. But if you are going to begin with such an abundant proteid diet as this your patient should be carefully watched, for the rapid alteration in his tissues may make him feel tired and out of sorts. Usually it is better to order the diet that was given to the lady whose case I mentioned. She only got through 2lbs. of lean steak, with a little toast, in the day, and I do not think you ought to undertake the case at all unless you can see the patient again within a week after the beginning of the treatment, and you are probably inducing too rapid a metabolism if the patient loses at a greater rate than 3lbs. a week. It is true our hospital patient lost more, but then he was a very big strong man, and we were able daily to watch him. There is no reason to hurry, and clearly it is an advantage for the body to gradually accommodate itself to its altered metabolism. At the end of the week you will be able to decide whether to increase the proteid or to allow a little fat and starch, and by using your judgment you will reduce your patient to such a weight that he will feel comfortable. As his weight slowly decreases you may gradually permit him to take a little toast or other carbohydrate to break the monotony of the diet, and when you have reduced his weight sufficiently he will keep at that reduced weight if he always eats sparingly of bread, takes very little butter, not much milk in his tea, and avoids sweets and large quantities of beer. He should, of course, take a fair amount of exercise. Do remember there is no special diet for him. Talk over with him what articles of food he likes best, and then arrange his proteids, carbohydrates and hydrocarbons suitably, and bear in mind, if there is any evidence that the diet is doing harm, you must leave it off. The amount of weight that each patient should lose must vary in each case, depending upon the excess of fat he had to begin with. I think most patients will be benefited by the loss of about a stone; above everything do not go on recklessly reducing the weight. Sometimes, as in the case I mentioned, the patient is so

pleased with his loss of weight that it is difficult to restrain him from making himself too thin.

You will often be asked whether patients can take such quantities of meat. They assure you that the very idea is repugnant, and they know they will never be able to manage it. I can only say I have never known anyone fail who honestly tried it. It means, of course, a cook who knows how to cook a steak, and because a steak is better cooked on a grill than in any other way, men who are undergoing the treatment prefer to take as many meals as possible at a club or restaurant. You, however, come across some people whom it is impossible to treat, for they have as bad a craving for carbohydrates, especially sugar, as a drunkard has for alcohol, and they seem as powerless to restrain their craving as he is to restrain his. In both cases no doctor can supply such a deplorable want of will power.

The great mistake in Banting's diet was that he allowed too little fluid. It is clear that as such large quantities of the products of destructive metabolism, and all the urea that results from the proteid diet have to be got rid of, it is well to wash the tissues out thoroughly; therefore, allow these patients plenty to drink—a cup of weak tea when they wake, weak tea for breakfast, a glass of water in the middle of the morning and on going to bed at night, a cup of tea in the afternoon, and a little whisky and water at lunch and dinner would hardly be too much, but many patients prefer to take less. There is no harm in a cup of black coffee after lunch and dinner, and smoking need not be given up.

You may often see extremely fat women who suffer from chronic bronchitis. Once such a one came into the hospital with great dyspnœa, and as it seemed likely that her difficulty of breathing was enhanced by the weight of fat which the ribs had to move up and down we gave her a proteid diet. It diminished her weight somewhat, but she died of her bronchitis, and my impression is that if you attempt to diet these people you should proceed very slowly and cautiously.

I need hardly say you will have nothing to do with the various quack remedies which are sold to make fat people thin, for some of them act by producing dyspepsia, as a result of which patients eat less and consequently lose weight. Nor should you give your patient thyroid gland preparations, they undoubtedly lead to a loss of weight, but they cannot be taken in large quantities for a long time without running great risk of producing symptoms of thyroid poisoning.

Now let us turn our attention to those patients in whom loss of weight without any organic cause to account for it seems to be the sufferer's chief trouble. The most typical of these cases are those which are said to be suffering from anorexia nervosa. The patient refuses food or takes very little, and, as a result of this, she slowly wastes, but the striking thing about it is that the wasting is so slow; this is partly because she takes no exercise and lies down a good deal, but even then she wastes far less rapidly than a healthy person would under similar circumstances. Often she does not refuse her food, but vomits it directly it is taken; often there is considerable repugnance of food associated with the vomiting. The patients who vomit waste very slowly. I have known a woman vomit after every meal for nine months, and yet remain alive at the end of it. In rare cases the vomiting is replaced by diarrhœa. I have come across two or three such cases, in one of them hysterical diarrhœa lasted for very many years. The most powerful astringents had been given both by the mouth and the rectum, but without any effect. The wasting may be very extreme in anorexia nervosa; the patient is often literally nothing but a bag of bones. I remember one woman who was so thin that she could not stand, and the manservant who carried her upstairs at the nursing home to which she was sent remarked that she would never leave the house again except in her coffin. He, however, turned out to be a false prophet, for in eight weeks she walked out. Another woman, 5ft. 10in. in height, weighed 90½lbs. or 6st. 6½lbs.; another, who was about 5ft. 7in. high, weighed 4st. 9¾lbs. A girl, aged 13, who was fairly tall for her age, weighed 4st. 3½lbs. These weights—which are all without clothes—will suffice to show how great the wasting may be. The skin is harsh, dry, wrinkled and often of a dirty brown hue, it hangs loosely on the body, it is anæmic, the nails are pale and the hair is thin, the patient is weak and feeble not only in body but in mind, the bright and cheerful girl has become listless, uninteresting and apathetic, and usually these patients say they do eat. The great majority of them are women, but occasionally the disease exists in men. It is most common between 17 and 37, but I have had one patient who, when first affected, was only 12½ years old; she made a complete recovery.

The condition is not usually difficult to diagnose, for by the time you see the patient

the condition can, at her age, hardly be anything else than anorexia nervosa. The disease most likely to be overlooked is, I think, phthisis, but diabetes, gastric ulcer, and malignant disease must all be considered. The case about which I have felt most qualms was one which one doctor had said was Addison's disease, because with the wasting the skin had become dark and dusky; the rapid improvement under appropriate treatment, however, showed that anorexia nervosa was the correct diagnosis. To show you how easy the condition is to diagnose, I may mention that I have hardly ever seen a mistake made when all the possibilities have been fairly and fully considered.

Now as to treatment. You must obtain the patient's consent and that of her friends to absolutely isolate her from all friends for from six to eight weeks; you must during some six weeks keep her absolutely in bed in a large airy room; you must provide a nurse who is kind, cheerful, but firm; you must have your patient massaged twice daily; and lastly you must be prepared to see that she is abundantly fed. Each of these points must be considered in detail.

The isolation must be absolute, and by this I mean that the only people who during the term of treatment may be allowed in the patient's room are the nurse, the masseuse, a maid to do the grate and clean the room, and the doctor. If I have a patient in a nursing home I never allow even the matron of the home to enter on any pretext whatever. The isolation extends to letters, the patient must neither receive nor send them, and it is absolutely useless to attempt complete isolation in the patient's own home. Unless you may select the lodgings or home refuse to treat the case. Often the friends and patients rebel strongly against the isolation, but by persuasion you can generally get your own way; if you cannot, do not treat the case. My greatest difficulty was with the mother of the girl aged 13. The mother (she was a Protestant) for a long while demanded that a priest should be allowed to visit the child twice a week. Finally, however, she gave way.

The rest, too, must be absolute. The patient must be kept in bed continuously night and day for from four to eight weeks, according to the severity of the case. If possible, she should not get out to relieve the bowels and bladder; at any rate, this is the only occasion on which she may get out. If the case is severe, but yet is doing well, she will, when she is not feeding or being massaged, doze or sleep away most of the twenty-four hours. So striking is this, that once a nurse who was nursing her first case of the kind sent to me urgently to say she thought the patient was dangerously drowsy. When the patient is at this stage she should not read nor write, nor work nor talk—in fact, she is to rest absolutely. Sometimes later on in the case, when she is not so sleepy, I let her read a little, write a little, or work a little, but I only do it when I have been begged very hard, and it seems that the patient is getting bored. I am suret hat the more complete the rest is, the better, and I must prefer to make it absolute for at least a month. It is important to choose a large airy room, for it is much the best plan for the nurse to sleep in a separate bed in the same room; she can then give the patient a feed in the night, and she can see that she does not get out of bed. I have always found one nurse enough. She can get out twice a day while the massage is going on, or when the patient is sleeping. After the first few days, if the patient can be trusted, the nurse can leave the room for her meals, although as the room is large she generally likes to take her meals in the patient's room, and there is no objection to this. You must for these patients provide kind, firm nurses who are enthusiastic about getting the patient well, and if you do you will find that this arrangement works very well, for so enthusiastic is the nurse on looking after the patient that it is difficult to get her to go out at all.

There is usually no difficulty about the massage, the whole body should be rubbed. It is well, generally, to begin something like this:—Ten minutes the first morning and the first evening; twenty minutes morning and evening the second day; thirty minutes morning and evening the third day; forty the fourth day; and an hour morning and evening the fifth day. An hour morning and evening should be maintained throughout the case until ten days before the patient leaves the home, from when the time each day may be gradually lessened, so that when the patient leaves she is not massaged at all. Menstruation is no bar to massage, but during the menstrual period the masseuse may omit to massage the abdomen. Occasionally you will be fortunate enough to find an enthusiastic nurse who will do the massage and all the nursing herself, but this is exceptional. Generally the masseuse comes for an hour in the morning and an hour in the late afternoon. It is well not to give any food immediately before the massage, but some should be given directly after, and then the

patient should compose herself to sleep. There is no need to use electricity, it is an additional worry to the patients and they do very well without it.

The last point is the most essential, namely, the patient must be overfed. It is very important to remember that no special dietary is necessary. Your patient can have whatever is going in the house, provided that it is plain, simple, and nourishing food. Usually during the first day you should give nothing but about three pints of milk in the twenty-four hours in frequent feeds of small quantities at each feed. The next day some kind of infants' food is added to the dietary, about three feeds of it in the twenty-four hours. Patients generally prefer Benger's, because it is very easy of digestion, but any good infants' food will do. The diet is gradually increased, until by the fourth or fifth day the patients are having an enormous quantity of food. I will give you two or three examples of what they rapidly attain. This is the dietary of one patient after she had been under treatment a few days :—

7.45 a m. Cup of tea, piece of bread and butter.
8.30 ,, Breakfast : tea with plenty of milk, abundance of bread and butter and toast, and 2 eggs.
10 ,, ½-pint of beef tea and some toast
12 ,, ½-pint of Benger's food.
1.15 p.m. A large slice of mutton and vegetables and a large helping of custard pudding
3 ,, ¾-pint of cornflour with an egg in it.
4.30 ,, Tea with plenty of milk, abundance of brown bread and butter and an egg.
6 ,, ½-pint of beef tea with toast.
7.30 ,, Dinner ; a large helping of chicken and vegetables, and a large helping of milk pudding.
10.15 ,, A basin of Savory & Moore's food with an egg in it.

This patient, therefore, every day was having four large meals, 13ozs. of cornflour, 28ozs. of infants' food, a pint of beef tea and 5 eggs. At one time of her treatment she was gaining in weight 18ozs. a day.

As another example, I may give you the dietary of a child, aged 13, whom I have already mentioned :

7 a.m. 8ozs. of milk with a little tea and a biscuit.
8.15 ,, Egg and bacon and large amount of bread and butter, and 10ozs. of milk.
10 ,, 10ozs. of milk,
12 a.m. A breakfast cup full of bread and milk.
1.30 p.m. Mutton cutlets, cauliflower, potato, milk pudding, an orange, plenty of bread and 10ozs. of milk.
4.30 ,, Large quantity of bread and butter and 10ozs. of milk.
7 ,, Wing of a chicken, bread sauce, spinach, potatoes, bread, rice pudding, stewed pears, and 10ozs. of milk.
9.30 ,, Cup of prepared sago.

During the night this child took 10ozs. of milk and some biscuits.

As one more instance I will give you the diet of one of Weir Mitchell's patients :—

6 a.m. 10ozs. of raw meat soup.
7 ,, Cup of coffee.
8 ,, A plate of oatmeal porridge with a gill of cream, a boiled egg, three slices of bread and butter, and cocoa.
11 ,, 10ozs. of milk.
2 p.m. ½lb. of rump steak, potatoes, cauliflower, a savoury omelette, and 10ozs. of milk.
4 ,, 10ozs. of milk and three slices of bread and butter.
6 ,, A cup of gravy soup.
8 ,, A fried sole, roast mutton, French beans, potatoes, stewed fruit, cream, and 10ozs. of milk.
11 ,, 10ozs. of raw meat soup.

At first there may be a little difficulty in getting a patient who has for months refused most of her food to take such diets as these, but if your nurse is a good one and you are firm, the patient is feeding properly and regularly within twenty-four hours of the commencement of the treatment. If, before she first came under observation, she had been vomiting, she may be a little sick after some of the first few feeds, but if you persevere the sickness soon disappears. I do not want you to think that there was any difficulty with any of the patients who took these enormous diets. They took them willingly and liked them, because they felt they were gaining strength. Also please notice that no special food is necessary. Always consult the patient as to what she likes best, and draw up the diet list accordingly. This is the reason why the first of the three patients just quoted did not drink milk. She disliked it, so I let her make up with five eggs instead. You should not give general directions about the diet. You should write out a diet list, tell nurse to keep to it as nearly as possible, and to put in a book

precisely what the patient has and when she has it. You thus keep a check on what is going on, and the patient sees that her diet is a matter of great importance.

No drugs are required, except that usually a little cascara sagrada is necessary to keep the bowels gently open. Sometimes it is well to help its action with a glycerine suppository.

About a week before the patient leaves the home you should gradually diminish her food so that she is taking four good meals a day, a glass of milk at 11 a.m. and another on going to bed, when you discharge her as cured.

The duration of the treatment varies with the degree of wasting and the rapidity of improvement. Usually the patient is completely restored to health in seven or eight weeks. As examples of the rate at which the weight is added I will quote you two cases:—

Miss Y.—

	Weight.			Gained.
	Stone.	lbs.	ozs.	
Oct. 2nd ...	4	3	6 ...	—
„ 9th ...	5	0	2 ...	10 lbs. 12 oz.
„ 16th ...	5	2	2 ...	2 „ 2 „
„ 23rd ...	5	6	8 ...	4 „ 6 „
„ 30th ...	5	11	4 ...	4 „ 12 „
Nov. 6th ...	6	2	12 ...	5 „ 8 „
„ 13th ...	6	7	10 ...	4 „ 14 „

Miss Z.—

Aug. 31st ...	6	6	8 ...	—
Sept. 7th ...	6	7	8 ...	1 lb. 0 oz.
„ 14th ...	7	0	0 ...	6 „ 8 „
„ 21st ...	7	7	10 ...	7 „ 10 „
„ 28th ...	8	2	0 ...	8 „ 6 „
Oct. 5th ...	8	4	0 ...	2 „ 0 „
„ 12th ...	8	8	0 ...	4 „ 0 „

As a matter of practice you will find the chief objection to this treatment is its expense. It cannot be done in a large hospital, at any rate if a medical school is attached to it, for each patient is seen by so many people that isolation is impossible; nor is it possible in nursing homes where each patient has only a separate cubicle. Therefore it is expensive. Your patient must expect to pay if she is to have a large airy room, the services of a good nurse and a good masseuse, and a very liberal diet, and the matron who keeps the nursing home is to make any profit at all on the case. The doctor's fees are the least important part of the expense, for if the nurse is one whom he knows and can trust, and who has had experience in such cases before, he need not visit the patient oftener than twice a week after he has seen the case properly started, provided of course that the nurse undertakes to send for him if anything is wanted.

Naturally you want to know how to tell whether a case is suitable for this treatment. The most suitable cases are those in which the wasting is most marked. Some hysterical patients are sick, or take very little to eat, and yet waste but little. They will not be much improved by this treatment. Another group of cases that are not benefited are those that are tending towards mental disease, and it is not uncommon to find hysterical patients on the borderland between the sane and the insane. Then, again, those in whom hysterical symptoms other than refusing food or vomiting are well marked, do badly—for example, those in whom anorexia nervosa is complicated by hysterical anæsthesia or paralysis, do not do well. Lastly, I think, if you decide to adopt the treatment for a person, who in addition to hysteria is also suffering from some organic disease, you should do it very slowly and cautiously. In a typical case the cure is so wonderful and striking, for a bedridden skeleton of a girl, who eats nothing, is in eight weeks converted into a plump woman, able to walk some miles, that you are often asked to undertake the treatment in unsuitable cases. In such cases, when you have refused to undertake the case, the friends often say, "Very well, if you won't, we will go to somebody who will." These people then generally fall ultimately into the hands of quacks, so I think it is fair for you to say to them, "I will undertake the case for a fortnight, provided that you will altogether give up the treatment at the end of that time if it is doing no good, and if it is doing good I will continue it."

Usually the cure is permanent, and the patient is in every way healthy. She eats well, sleeps well, and can take plenty of exercise. I have heard of cases years after they were discharged from the home, and they have remained healthy members of society. Occasionally there are one or two relapses, but then another course of treatment quickly cures. I know of no harm that can result from the treatment, although I have known two patients die while undergoing it, but the first was a very unsuitable case, for the girl was out of her mind, and she would, I think, have died under any treatment. In the second case there was no post-mortem examination, and I cannot help thinking that there may have been some organic disease behind a large collection of hysterical symptoms. In neither case was there any evidence that the treatment had anything to do with the fatal

result, it was only tried because everything else had been tried without success.

You will often be asked whether it is necessary to carry out the treatment so rigorously as I have told you. For genuine cases of anorexia nervosa it most certainly is, but you will come across a large number of fanciful patients, mostly women, and generally between fifteen and thirty-five years of age, who say they cannot eat this and they cannot eat that, and who live among sympathetic friends who support them in these fancies. These patients are always thin and generally weak, and it is impossible for them to gain in strength while they are surrounded by a number of relatives. They are very frequently much benefited by being treated in the same way as sufferers from anorexia nervosa, but they need not be so strictly isolated. They may receive letters and write them, and see an occasional visitor, provided he or she is not of the sympathising type. Still even in these cases you will do well to err in the direction of too strict rather than too lax isolation. Usually four weeks' treatment suffices. In this time the patient gains about from 12 to 18lbs. It is demonstrated to her that she can eat, and she does not as a rule relapse.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

CASES UNDER DR. PYE-SMITH.

MARY 27. Chronic Bright.
28. Chlorosis.
29. Mitral regurgitation following rheumatism.
35. Phthisis, left apex. Hæmoptysis.
37. Splenic enlargement. Cause obscure.

PHILIP 25. Right basal pneumonia.
26. Lardaceous disease.
27, 33. Empyema. Operation.
29. Laryngeal obstruction. ? Syphilis. Laryngotomy.
32. Phthisis. Hæmoptysis.
34. Chronic Bright. Pericarditis.
35. Chronic Bright. Bronchitis and emphysema.

CASES UNDER DR. TAYLOR.

MARY 38. Phthisis. Hæmoptysis.
39. Gall-stones. Operation.
MARY 41. Chronic uræmia. Fits.
42. Acute rheumatism.
43. Right pleurisy. Blood-stained fluid. ? Growth.
45. Typhoid.
50. Bronchitis. ? Cirrhosis. ? Aortic stenosis.
Cot 56 Broncho-pneumonia.
Cot 57. Diphtheria. Tracheotomy.

STEPHEN 1. Chorea. Mitral regurgitation.
6. Pleurisy. Paracentesis.
7. Typhoid. Relapse after four weeks' normal temperature.
8. Bronchitis. Emphysema.
9. Renal colic.
10, 15. Enterica.
11. Double aortic disease and mitral regurgitation. Presystolic thrill.
12. Acute rheumatism. Mitral systolic bruit. (Recent bruit.)
16, 17. Mitral disease.
20. Diabetes mellitus.

CASES UNDER DR. WASHBOURN.

PHILIP 1. Tubal nephritis.
4. Interstitial nephritis. Hypertrophied heart.
6. Ulcerative endocarditis.
11. Peripheral neuritis.
12. Pleuritic effusion.
18. Phthisis.

MARY 15. Broncho-pneumonia. Empyema.
16. Aortic regurgitation. Hæmatemesis.
21. Carcinoma of liver and pylorus.
23. Purpura hæmorrhagica.
24. Mitral disease.

CASES UNDER DR. BRYANT.

STEPHEN 22. Enterica.
23. Perihepatitis.
27. Psoas abscess. Phthisis.
29. Atonic dyspepsia. Dilatation of stomach.
30. Empyema.
32. Carcinoma pylori.
33. Acute rheumatism. Mitral regurgitation.
34, 35. Aortic disease.
36. Carcinoma pylori. Dilatation of stomach. Jaundice.
37. Malaria.
38. Chronic mediastinitis.
39. Gout.
40. Chronic bronchitis.

MARY 1, 2, 5, 6, 12. Phthisis.
3. Malignant growth of liver.
7. Appendicitis. Operation.
8. Enterica. Abscesses.
10. Pleuritic effusion. ? Cause.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

NAAMAN	5.	Tuberculous knee.
	6.	Tuberculous inguinal glands.
	8.	Contracted fingers. Dupuytren's variety.
CHARITY	9.	Tuberculous knee.
	10.	Displaced semilunar cartilage.
	16.	Submaxillary nævus. Excised.
	20.	Infantile paralysis.
ASTLEY COOPER	7.	Compound dislocation of elbow.
	13.	Fractured femur.
	32.	Fractured femur.

CASES UNDER MR. DAVIES-COLLEY.

LUKE	2.	Old fractured patella. Wired.
	6.	? Tuberculous knee.
	8.	Old fractured patella. Wired.
	12.	Bilateral cysts of epididymis. Excised.
	13.	Cyst of epididymis. Multiple. Excised.
	15.	Arthritis of wrist and elbow, with sinuses. ? Tuberculous. ? Glanders.
LYDIA	1.	Mastoid abscess. Incised.
	4.	Bitten tongue. Hæmophilia.
	5.	Spinal caries.
	17.	Acute periostitis of tibia. Incised.
	17.	Suppurating submaxillary salivary gland. Excised, and two calculi removed.
	20.	Intracapsular fracture of neck of femur.
	21.	Congenital talipes equinus.
	22.	Endosteal sarcoma of mandible. Excised.
CORNELIUS	6.	Fractured femur.
	13.	Fractured patella.
	14.	Fractured femur (left). Fractured tibia (left).

CASES UNDER MR. LUCAS.

JOB	3.	Psoas abscess.
	4.	Parotid sarcoma. Excised.
	16.	Stricture with extravasation.
	18 & 19.	Stricture with retention.
	21.	Stricture.
	25.	Recurrent sarcoma of muscles of thigh. Excised.
		Tuberculous carpus.
CHARITY	1.	Otitis media.
	1.	Mammary abscess. ? Tuberculous.
	5.	Œsophageal malignant stricture.
LYDIA	10.	Ovarian cyst. Ovariotomy.
	14.	Carcinoma mammæ. Excised.
	15.	Tuberculous kidney.
Cot C.		Tuberculous hip.

CASES UNDER MR. GOLDING-BIRD.

LAZARUS	7.	Epithelioma linguæ. Excised.
	8.	Recurrent appendicitis. Appendicectomy.
	17.	Suprapubic abscess containing foreign body (cloth). Incised.
LAZARUS	19.	Traumatic destruction of nose for plastic operation.
MARTHA	5.	? Irreducible femoral hernia. ? Hydrocele of hernial sac.
	8.	Carcinoma mammæ. Excised.

CASES UNDER MR. JACOBSON.

VICTORIA	2.	Lupus nasi.
	4.	Iliac abscess.

CASES UNDER MR. SYMONDS.

SAMARITAN	10.	Erysipelas of scalp.
LUKE	16.	Carcinoma recti. Inguinal colotomy previous to excision of rectum.
JOB	10.	Undescended testis.
	10.	Malignant gall-bladder. Jaundice. Ascites. Death.
MARTHA	13.	Empyema of antrum. Drained.
	14.	Epithelioma of upper lip.

CASES UNDER MR. LANE.

VICTORIA	6.	Moveable kidney. Nephrorraphy.
	7.	Old Pott's fracture. Fibula wired.
JOB	13.	Tuberculous knee. Erased.
	15.	Displaced semilunar. Excised.

CASES UNDER MR. DUNN.

MARTHA	10.	Contracted finger after whitlow.
	12.	Carcinoma recti. Excised.
Cot C.		Otitis media.
LAZARUS	2.	Stricture urethræ with right femoral and inguinal herniæ. Later recurrent after radical cure.
	12.	Carcinoma recti.

"Clinical."

JOHN	2.	Typhoid.
	3.	Pyopneumothorax. Phthisis.
	10.	? Sarcoma of kidney.
	12.	Hydronephrosis. Operation.
	15.	Elephantiasis. Optic neuritis. Albuminuria.
MIRIAM	17.	Gastric ulcer. Hæmatemesis.
	19.	Aneurysm of thoracic aorta.
	20.	Mitral stenosis and regurgitation. Sinus thrombosis.
	23.	Mitral regurgitation and stenosis. Tricuspid regurgitation.
	24.	Congenital heart. Pregnancy. Child born 31st. Mother and child well.
	25.	Carcinoma of kidney. Explored.
	26, 28.	Pleurisy with effusion.
	30, 31.	Mitral stenosis and regurgitation
Cot	34.	Broncho-pneumonia.
Cots	35, 36.	Diphtheria. Tracheotomy.

Notes from the Ophthalmic Out-Patient Department.

DURING the early part of 1897, an attempt was made to obtain some sort of a permanent record of the number and variety of the cases attending Mr. Brailey's Out-Patient Department.

At its inception the method adopted was to enter a few particulars, such as name, age, and diagnosis of each case, in a rough note-book kept in the out-patient room; and some figures compiled from these data will be found in the GAZETTE of February 19th, 1898.

With the advent of the Ophthalmic Ward Clerks the system was somewhat elaborated and a special register was started, by means of which the details of individual cases are rendered more readily accessible than has hitherto been possible.

At present the particulars noted for each individual case are as follows: Number of out-patient letter, date, name, age, occupation, eye affected, and diagnosis. In a very large number of cases further details of the observed lesion are noted; and when a patient is found to be suffering from an error of refraction, the retinoscopy results and those obtained by means of tests with trial lenses are also entered up. This portion of the register unfortunately shows many blanks; for in spite of the care and trouble the successive ophthalmic clerks have devoted to the work, even the diagnosis, is missing from no less than 106 of the cases treated during the last twelve months. Still it is hoped that the majority of these blanks will be filled up as the old letters of 1898 come in.

An alphabetical index of the names of the patients is prefixed to the year's cases, and makes a reference to any of those recorded in the register an easy matter.

The practical utility of entering up the refraction notes for future reference is at once obvious when it is realised how frequently patients come back after varying intervals, having mislaid or broken their spectacles, and pour out a woeful tale of having lost their letters (which at one time they were allowed to take away with them) during their last fire, funeral, flitting, or other great domestic event. In such cases, instead of having to work out each refraction again in its entirety, the names of the patients can be turned up in the register and suitable lenses rapidly fitted.

Such a register has now been in use since the 1st of January, 1898, and from it has been compiled the accompanying tabular analysis of the diseases that have presented themselves for treatment during the past year. This table, apart from other considerations, is of interest in showing the number and variety of cases in a special branch—ophthalmic surgery—that may be observed and studied within the four walls of our own hospital.

The total number of new cases attending Mr. Brailey's out-patients for the year ending December 31st, 1898, reached 2920—a decrease of 100 as compared with the corresponding period ending December 31st, 1897.

At the same time this total includes an increase of precisely the same number (100) of patients seeking relief from errors of refraction. This is a somewhat important point, for during the past four years there has been a marked and steady increase in the numbers of patients of this class who present themselves for treatment. This fact, whilst extremely gratifying to those working in the refraction room, greatly increases the work of the department and also lessens the percentage of "interesting" cases. (As will be seen from the table "Errors of refraction" are responsible for 1308 out of 2920 new cases, *i.e.*, 44·4 per cent.). No doubt part of this increase is due to the more intelligent interest that is taken in every succeeding year in the eyesight of school children.

The next most important class of case that comes under observation is conjunctivitis, and a matter in this connection to which considerable attention has been devoted during the past year, is the microscopical diagnosis of these cases.

As is well known, every case of acute conjunctivitis (with of course the exception of those cases of hyperæmia the result of traumatism) is due to the invasion of the conjunctival sac by micro-organisms and their multiplication therein; also that each of many different bacteria may act as the specific agent in the causation of conjunctivitis—that each species "breeds true," and that the presence of each separate species can at least be suspected by the clinical appearances of the resulting lesion. Still the diagnosis of each case needs to be confirmed by the result of a microscopical examination of cover slip films prepared from the conjunctival secretion. The cases of conjunctivitis in the accompanying table have been classified under the name of the organism that is recognised as the specific factor in the causation of each inflammatory process; and apart from relieving one from the use of names such as spring catarrh, acute catarrhal conjunctivitis, and the like, names that are cumbersome, confusing, and inaccurate in themselves, and convey no information either as to the etiology or pathology of the lesion, this method is preferable in that it shows the relative frequency of the various organisms in the causation of conjunctivitis.

Whilst upon the subject of conjunctivitis, a few words may be of interest on that form due to the Koch-Weeks bacillus, but known to the gentry and nobility of Maze Pond as the "blight." This form of conjunctivitis if properly treated, *or not treated at all*, practically never causes any permanent defect of vision; but when, as so frequently happens, the fond but ignorant parents tie the eyes up with a bandage and handkerchief, or apply hot compresses or poultices, the superficial layers of cornea are destroyed and nebulæ result—a fact which has direct bearing on the future wage earning capacity of the individual affected.

LIST OF DISEASES.

1.—LIDS.

Cellulitis	4	
Ciliary Blepharitis	101	
Lippitudo	3	
Chancre, Hunterian	1	
Coloboma, Congenital	4	
Cyst, Tarsal	45	
Sebaceous	3	
Dermoid	1	
Ecchymosis	4	
Eczema and Impetigo	3	
Epicanthus	5	
Hordeolum	22	
Molluscum Contagiosum	1	
Nævus, Capillary	4	
Œdema, Solid of Hutchinson	1	
Papilloma	2	
Ptosis, Congenital	4	
Rodent Ulcer	1	
Trichiasis	16	
Ectropion and Entropion	4	
Urticaria	2	
Wart Horn, Sebaceous	1	
Xanthelasma	3	235

2.—LACHRYMAL APPARATUS.

Dacryocystitis, Acute	7	
Chronic	21	
Epiphora	13	
Fistula Lacrimalis	3	
Mucocele	4	
Stenosis of Lower Punctum	1	49

3.—GLOBE AND ORBIT.

Buphthalmos	1	
Phthisis Bulbi	3	
Rupture of Globe	3	
Abscess of Orbit	1	
Exostosis „	1	
Gumma „	2	
Sarcoma „	2	
Suppurating Socket	13	
Tenonitis	1	27

4.—CONJUNCTIVA.

Hyperæmia, Traumatic	15	
Burn by Hot Metal	8	
Lime	3	
Carbolic Acid	1	
Conjunctivitis due to the Gono-coccus (in adults)	2	
„ (in newly-born infants)	14	
Diplo-bacillus Lacunatus	67	
Klebs-Löffler Bacillus	2	
Koch-Weeks Bacillus	185	
Streptococcus Pyogenes Longus	7	
Staphylococcus Aureus, etc.	9	
Conjunctivitis not diagnosed microscopically	27	
Cyst, Dermoid	2	
Implantation	1	
Ecchymosis	6	
Foreign bodies removed	27	
Folliculosis	7	
Phlyctenules	124	
Pterygium	2	
Sarcoma, Melanotic	2	
Symblepharon	2	
Trachoma	28	
Tuberculosis	1	
Wound, Lacerated	2	534

5.—CORNEA AND SCLERA.

Abrasion	7	
Abscess (Onyx)	2	
Episcleritis	2	
Herpes	1	
Keratitis Interstitial, Acquired	41	
Congenital	1	
„ Marginal	10	
„ Superficial	50	
Kerato-conus	4	
Kerato-globus	1	
Leucoma and Nebula	25	
Leucoma, Adherent	5	
Nebula, Vascular	7	
Staphyloma, Anterior	3	
Ulcers—		
Dendritic	1	
Infective (plus Hypopion)	10	
Necrotic	2	
Serpens	1	
Simple	116	
Wounds, Perforating	8	
Lacerated	2	299

6.—LENS.

Cataract, Congenital (Lamellar)	7	
Infantile (Ant. Pyramidal)	2	
Senile, Cortical	4	
Nuclear	40	
Post. Polar	4	
Incipient	14	
Traumatic	11	
Web	2	
Dislocation, Congenital	2	
Traumatic	1	87

7.—IRIS, &c.

Coloboma, Congenital	2	
Cyclitis	2	
Irido-cyclitis (Keratitis Punctata)	10	
Irido-donesis	1	
Irido-dialysis with Hyphæma	1	
Iritis, Rheumatic	1	
Syphilitic Congenital	1	
Acquired	14	
Traumatic	8	
Mydriasis after atropine	2	42

8.—CHOROID.

Atrophy (with High Myopia)	6	
Choroiditis, Central	2	
Disseminated	11	
Guttate	1	

Coloboma	3	
Rupture	1	24
9.—VITREOUS.		
Hæmorrhage...	5	
Hyalitis	1	6
10.—GLAUCOMA.		
Absolute	6	
Primary	21	
Secondary	8	35
11.—OPTIC NERVE AND DISC.		
Atrophy, Primary	8	
Post Neuritic	8	
Neuritis due to Bright's Disease ...	2	
„ Embolism of Central Artery	2	
„ Gumma	2	
„ Cerebral Tumour	1	
Neuro-retinitis	1	
Pseudo-neuritis	1	
Opaque Nerve Fibres	2	27
12.—RETINA.		
Choroido-Retinitis	1	
Detachment	9	
Retinitis, Albuminuric	2	
Diabetic	1	
Pigmentosa	5	18
13.—MISCELLANEOUS.		
Chancre of Skin of Neck	1	
Diplopia	3	
Exophthalmic Goître	2	
Hemianopia, Bilateral	1	
Fall on head	2	
Micropsia	1	
Neurosis	2	
Nystagmus	2	
Ophthalmoplegia Externa (Syphilitic)...	8	
Ophthalmoplegia Interna (Post Diphtheritic)...	3	
Paralysis of Facial Nerve	2	
Sixth	6	
Simulatio	1	
Toxic Amblyopia, Tobacco... ...	20	
? Alcohol	3	57
14.—ERRORS OF REFRACTION.		
Asthenopia (including Hypermetropia and low degree of Myopia)	805	
Myopia between 5D and 10D ...	30	
„ „ 10D and 25D ...	17	
Presbyopia	342	
Aphakia (after Cataract Extraction)	14	
Convergent Strabismus Alternating	53	
„ „ „	33	
Divergent Strabismus	14	1308

From the above table a second one has been abstracted, which demonstrates the fact that, after subtracting those suffering from errors of refra tion from the grand total of cases for the year, every sixteenth patient who came under observation in the Ophthalmic Out-Patient Department was seeking relief from a lesion or lesions directly due to congenital or acquired syphilis. Comment is unnecessary.

DISEASES DUE TO SYPHILIS.		
Chancre (Primary) of Lower Eyelid	1	
„ „ Skin of Neck	1	
Choroiditis Disseminata	11	
Choroido-Retinitis	1	
Dermatitis (secondary) simulating Ciliary Blepharitis	1	
Gumma of Orbit	2	
„ Ciliary Body	1	
Hyalitis	1	
Iritis, Congenital	1	
„ Acquired, Secondary ...	13	
„ „ Tertiary	1	
Keratitis, Interstitial, Congenital...	39	
„ „ Acquired ...	1	
Neuritis (due to Gumma of Nerve)	2	
Neuro-retinitis	1	
Optic Atrophy, Primary	7	
Paralysis of Third Nerve	8	
„ Sixth Nerve	6	98

J. E.

Some Cases of Scarlet Fever.

THE following two groups of cases of scarlet fever present a certain amount of interest. In each group the first cases were impossible to recognise, the middle cases were extremely doubtful, while the final cases were typical and settled the diagnosis.

I. A family, J——, consisting of father, mother and two little boys, aged two and six years. They all went for a change in the country at N——; during their stay there there was an epidemic of sore throats. The father had a bad throat lasting about a week, but was not actually laid up; the mother had a sore throat and was in bed two or three days; the boy, aged six, had a throat and a transient rash and a high temperature for a few days, but soon got right again. These three were all ill during the same week and were looked upon as cases of bad throats of the current epidemic type. The family came home a week after the commencement of these throats all apparently convalescent. Two days after their return, I was called to see the little boy aged two. He had all the symptoms of scarlet fever, abundant rash, tonsils covered with lymph, furred tongue and high temperature. His illness ran an ordinary course of six weeks with complete desquamation and, a few days' albuminuria at the end of the third week. The boy, aged six, had no signs of desquamation although it was repeatedly looked for, but at what would correspond with the third week from his rash he had albuminuria lasting a week, and about the same time a systolic bruit at the apex of the heart lasting about a month. Neither father nor mother had any further symptoms, though all four mixed together during the whole six weeks.

II. In this series the household consisted of seven, mother, father and four children, aged ten, eight, six and

four, and the father's brother. Two years ago I had attended in a different house the father and this same brother with scarlet fever, the mother assisted to nurse them but did not have it; the children were isolated early and all escaped.

In the middle of November the boy, aged ten, had a sore throat, which looked like a follicular tonsillitis; he was ill, with a temperature of 100° for three days, and had no further symptoms. While this one was recovering, the boy, aged six, had a similar throat with a temperature 102° for two days and very severe earache; the throat soon got well, but the boy was ill for ten days with the earache, deafness and weakness. No rash was ever seen on this boy, and it was three weeks before there was any signs of desquamation, and then only about the feet. During this long illness, the baby, a little girl aged two years, developed what seemed to be simply bronchitis with a slight sore throat, but on the third day a rash appeared on the chest and abdomen. The question of scarlet fever was then raised, but in the evening there was nothing to be seen. The next morning there were some granulating surfaces on the left tonsil and the left side of the palate; they did not look at all like diphtheria, but their nature was not recognised until the fourth case showed itself. This throat was very troublesome; the patches spread on the fauces and to the opposite tonsil; they cleared up for about twenty-four hours after painting with 1% solution of Hydrarg. Perchl. but kept re-collecting; it was finally cured in a week from its commencement. This child desquamated about the knees, hands and feet, but not on the chest and abdomen where the rash was seen. She also had otorrhœa, lasting three days.

A week after the baby sickened, and about ten days from the onset of the first case in the house, the little girl, aged eight years became out of sorts and vomited: the next evening a typical scarlatinal rash showed itself. The rash was very extensive, affecting the whole body except the face, which was simply flushed. The tongue was very furred, and cleaned up later in the strawberry-like manner; the throat was injected but there was no lymph; the temperature was never higher than 102° and then only for two days. This child never seemed very ill, the only complication she had was otorrhœa, lasting ten days. She desquamated very partially; about the face, neck, chest, hands and feet.

South Norwood, S.E. GERALD S. HOVENDEN.

Nursing News.

Nurse Latham concluded three years' training on January 31st, and has left the hospital to take up her duties at the Institution.

On February 1st, Nurse Barnes left us after nearly seven years' excellent work. She has also joined our private nursing staff.

Probationer Finnemore has been appointed Head Nurse in Miriam ward.

Guy's Hospital Debating Society.

A MEETING of the Debating Society was held in the Club Smoking Room on Saturday, January 28th. Mr. V. E. COLLINS was in the chair, and over fifty members were present.

Mr. A. E. H. PAKES, in a maiden speech, proposed "That the policy of England both in Egypt and China should be one of fearless expansion." He warned the House that the tendency to apathy to a subject like that under consideration, was one of the most formidable dangers that threatens an Imperial Government. Such periods of apathy had paralysed us in the past, and would do so again in the future, if we were content to rest on our oars, instead of fearlessly extending our dominions, and so our commerce. This extension was not only a question of moral right, but one of universal economy. The necessity for expansion was generally attributed to a universal and selfish policy. Mr. Pakes pointed out that this might be the case with most European nations, but not with England, who always conferred the blessings of civilisation and of an enlightened government on those parts of the world that had previously only known barbarism and tyranny. He then went on to prove that as we were the only nation that had adopted free trade, so our policy must be one of territorial expansion. Mr. Pakes then reviewed the history of the world since the creation, and finally asserted that the Anglo-Saxon or the Tartar race would be the predominant, as these were the fittest to survive, but he said that it was for the greatest good of the greatest number that the Anglo-Saxon should rule, and that it was our duty to do the utmost in the contest of the future. After making these generalisations, Mr. Pakes showed that they had special bearing upon our policy in both Egypt and China. Egypt as a nation, as a prosperous nation, owed its position entirely to England. The Cape and Cairo railway would open up thousands of miles in the centre of Africa, and the benefits would be untold, not only to us from a commercial point of view, but also to the people who inhabit those lands. Mr. Pakes said that on account of the extent of our trade in China, and the amount of British capital invested there, we must make our position strong, and fearlessly oppose any fresh demands of foreign powers. In conclusion, he said that as such vital importance hangs upon our commerce, and as Egypt and China are most important centres for our commerce, we must do all in our power to strengthen and extend our position there. By so doing we shall gain another point for the mastery of the world, and in saying this, Mr. Pakes congratulated himself with pride upon being an Englishman, for Englishmen alone could bring freedom to mankind.

Mr. STOEHR, after congratulating Mr. Pakes on his eloquence as well as his nationality, went on to criticise the motion, less for what it said than for the spirit it implied. He was no enemy of expansion, but he found the present temper of the nation dangerously over-

confident, and he dreaded a reaction. Further, he detected something un-English in the hubbub being stirred up at home by people who cannot possibly know what they are talking about. Neither does there seem to be perfect concord between justice and freedom on one side, and the greed of dominion on the other. Warming to this argument, the speaker was heard to use an expression just one pennyworth stronger than parliamentary. Instant clamour came from the members on the cross benches, but the Olympian frown of the chairman sternly repressed disorder.

Mr. SHUFFLEBOTHAM said that Mr. Stoehr's speech reminded him of the song "'E don't know where 'e are," and that the opposition offered to the motion was not as strenuous as he had anticipated. Mr. Stoehr seemed to be in the position of a little Englander semi-converted. Mr. Shufflebotham then dilated on the fact that it was the duty, and it seemed to be the mission of Englishmen to colonise all the uncivilised parts of the world. Then reverting to the Egyptian question, he said that our position in the Nile Valley had only been gained by lavish expenditure of blood and treasure, and by making sacrifices greater than we had ever made for any other of our great possessions. We had been the means of striking a death blow to the barbarous tyranny to which the population of that country was subjected, and we had done this at a time when our foreign neighbours were unwilling to share our responsibilities. If we are to maintain our present position, we must not only defend what we have, but take our share in further expansion. He laid down that this was a national policy so firmly grounded in this country, that nothing on earth, not even the speech of Mr. Stoehr, could unroot it.

Mr. FORTESCUE-BRICKDALE said that he looked upon the question with a perfectly unbiassed mind, yet he would vigorously oppose the motion. He quoted the English translation of two inscriptions on the temple at Delphi (asking anyone to correct him if he erred), and endeavoured to prove that they had great bearing upon the subject under discussion. These inscriptions were (for no one questioned their accuracy), "Know thyself," and "Go not into excesses." He also pointed out that our vaunted civilization in Central Africa and elsewhere meant gunpowder and whisky. A nigger in trousers, using a knife and fork for dinner, was not civilisation, and certainly was not happiness.

Mr. FREMANTLE said he did not wish to know himself, and he would take care that he did not go into excesses. Enquiries into knowing one's self he regarded as an unseemly occupation, and with all deference to the previous speaker, he thought that it was outside the question. Mr. Fremantle then settled down to discuss the motion at length, and although his arguments seemed to support Mr. Pakes, he declared that he should vote with the opposition.

Mr. STAMM spoke for the first time. At the outset he asked Mr. Pakes for a definition of the word "Tartar." He waited in a state of bland expectancy for that gentleman's answer, but as this was not forthcoming he proceeded to confuse "Tartar" with "Tartan" and "Tartaric." After this slight diversion, Mr. Stamm reviewed the whole debate in a most philosophic way, and with much eloquence explained why he was in favour of "fearless expansion."

Mr. J. F. ROBINSON opposed the motion in a few well-chosen remarks.

Mr. R. THOMPSON, speaking as a Scotchman, said that he disliked the boastfulness and self-consciousness of Englishmen, and regarded our attitude in Colonial expansion as altogether unwarranted.

Mr. E. A. MILLER supported the motion because he had the welfare of the nation at heart. What we possessed in Egypt and China was our right, and it was our duty to stick to all we had.

Mr. S. J. ORMOND admitted great ignorance as to the geography of Africa, but in spite of this spoke for the opposition.

Mr. C. A. Bryan, Mr. F. C. Robinson and Mr. J. D. Pearson, in maiden speeches, then addressed the House, all speaking for the motion.

After replies had been heard from Mr. Stoehr and Mr. Pakes, the House divided. The motion was carried amid great applause by 25 to 10.

In moving a vote of thanks to the chairman, Mr. Shufflebotham said that it was a red letter day in the annals of the Society, as the House had heard no less than seven maiden speeches. Some of these were good, and all showed great promise. He hoped that the popularity of the Society would increase, not only among the senior men, but among those in the dissecting-room.

Guy's Hospital London University Club

THE annual general meeting and dinner was held under the presidency of Dr. Horrocks, at the Café Royal, on Thursday, January 26th.

At the annual meeting the following officers were elected for the following year:—President: Mr. Howse. Vice-Presidents: Dr. Horrocks and Mr. A. H. Tubby. Treasurer: Mr. F. Durham. Committee: Drs. and Messrs. Adeney, Bryant, Burgess, Collins, Eason, Galton, Hetley, J. Jewell, A. E. H. Pakes, G. B. Smith, Spriggs, Young. Secretaries; Messrs. C. H. Fagge and F. E. Walker.

The Treasurer then presented his accounts, duly audited, and showed a balance of £26 5s. 4d.

The annual dinner was then held, with Dr. Horrocks presiding, at which twenty-eight members and their friends sat down, amongst whom were—Drs. Galton, Hetley, Adeney, Pye-Smith, Bryant, J. Jewell, T. D. Lister, Tanner, Dakin, Meek, Fawcett and Spriggs, and Messrs. A. H. Tubby, G. B. Smith, C. H. Fagge and F. E. Walker.

The Club was also honoured by the presence as a guest of Dr. W. H. Crosse, who recounted some interesting anecdotes of Nigeria. Dr. Maillard, R.N., V.C., had also been invited, but owing to his return to the *Hazard* in the Mediterranean, was unable to be present.

Passim.

The Debating Society, under the presidency of Mr. V. E. Collins, last Saturday evening discussed "The Expansion of the Empire." The debate was remarkable for the quantity as well as the quality of the oratory, no less than seven men making maiden speeches. From the side of the Little Englander, Mr. Brickdale uttered an impassioned protest against the vices of our boasted civilisation, and Mr. Thomson, with equal eloquence and less obvious insincerity, bade us set our own house in order. But the President's smile, Mr. Pakes' (minor) rhetoric, and the fulness of the house were all expansive influences, and the result of the debate will go far to strengthen the hands of Mr. Chamberlain.

The Fourth Annual Dinner of the Dental Society will be held on Saturday, February 11th, at the Criterion. The President, Mr. Montague F. Hopson, will take the chair, supported by Mr. Davies-Colley, Dr. Washbourn, Mr. Maggs, and other members of the Staff. Tickets can be obtained on application to the Secretary, price 6s. each.

At a meeting of the Royal Medical and Chirurgical Society, on January 24th, Mr. Lucas read a paper on Gonococcal Joint Diseases in Infants, secondary to Purulent Ophthalmia. Attention was first drawn to this previously unnoticed condition by Mr. Lucas in 1885, when he wrote a paper on the subject, and cited three cases. Since then he has collected 23 cases, and recent bacteriological research has proved the presence of gonococci in the affected joints. Mr. Lucas has apparently entirely proved his case, and there seems no reason why joints should not be affected secondarily to infection of the mucous membrane of the eye, in the same way as they become infected through the urethral tract, but luminous facts sometimes take a deal of discovery.

In the *St. Bartholomew's Hospital Gazette* we find the following amusing story of one of the Staff, which some of our readers may have heard. For the sake of those who have not, it is worth quoting:—One of the surgeons of the hospital was going round his wards one afternoon with a dozen or so students. A certain case had just come in. The surgeon described the chief points of the case to the students, and laid some stress upon some one symptom which was a little peculiar. Then he turned to the first student and said, "Now, So-and-so, you have heard all about this case; what do you say? Would you recommend an operation?" The student, who did not know in the least whether it was a suitable case for operation or not, but thought that he ought to say something, answered boldly, "No." The surgeon then turned to the next student and asked his opinion. This individual, also not knowing what answer to give, but evidently thinking that the first man was a good lead, also said "No." Then the question went all round the class, and everybody agreed with the first two. "Well," said the surgeon, "you are all wrong, for I am going to operate." "No, you ain't," said a voice from the bed; "'ere's fifteen doctors say it ain't a case for operation, and I ain't goin' to let you operate on me!" And he took up his bed and walked. . . No names are given, but we believe that Mr. Butlin was the surgeon in question.

We have to record the death of Sir Alfred Roberts, which occurred on the 19th December, at Wentworth Falls, New South Wales. Sir Alfred Roberts was born in London in 1823, and educated at St. Paul's School and Guy's Hospital. He first bought a practice in Sussex, but emigrated to Australia in 1854, and settled in Sydney. He was Hon. Secretary and Consulting Surgeon to the Prince Alfred Hospital, Sydney, and Vice-President of the Carrington Hospital for Convalescents at Camden, New South Wales. He received his knighthood in 1883.

And yet another Club! Monday, January 30th, witnessed the foundation of the Guy's Hospital Chess Club. Dr. Shaw is the President, and Mr. A. E. H. Pakes the temporary Honorary Secretary. For those who take intellectual recreation as a contrast and relief to their daily work at the hospital, nothing is more suitable than a chess club. All men who wish to join are requested to communicate with the secretary.

New brooms sweep clean, but they have not quite swept and garnished Cornelius. The British workman is very much a child of Nature, and deeply implanted in the mind of every child is a passionate love for any destructive process, arising from the inherent charm

of doing something which is evident when done. A fortnight ago the last patient left Cornelius; within an hour several able-bodied men were cheerfully making the ward a wilderness. Having effectually done this, they rested upon their oars, figuratively speaking. They are still resting.

We would remind all men, especially those in the wards, that the two concerts given by the Nurses' Choral Society and Students' Glee Club takes place in about a week's time. Those who have not already taken tickets owe it to their consciences to do so promptly, as they can be obtained everywhere, from members of the two Committees, and in the offices of the Matron, Dean, Secretary to the Treasurer, or Counting House. A brief outline of the programme is as follows:—Piano solo, Miss Starling; May Day, Cantata by G. A. Macfarren; Solo, Nurse Daniell; Part-Songs by the Choir; Solos by Sister Christine, Mr. Parrott and Mr. H. J. Starling. Mr. W. R. Cazenove will sing on the 13th, and Mrs. Meredith and Miss Spalding will play a sonata for violin and piano on the following evening.

We are glad to welcome the first number of *The Broad Way*, the new Gazette of the Westminster Hospital men. The first number is a distinct success, and contains, among other good material, an excellent caricature of Mr. Stoneham, and some "Clinical Jottings," by an Old Patient. We wish the Westminster men every success in their new venture.

On Wednesday last one of the best-known Guy's nurses left the hospital in the person of Nurse Barnes, Staff in Miriam. She has been at the hospital for seven years, the greater part of which time she has spent in Clinical, with which ward her name is inseparably connected. The friend and occasional mentor of successive generations of embryo residents, she will be sadly missed by all who knew her. We can only wish her as successful a career in the Institution as she had at Guy's.

A Confession of Faith.

It was the night of the great gale. In the usual midnight altercation at Piccadilly-circus for the inside seats of omnibuses we had suffered defeat; we sat on the inclement top of the vehicle, a disconsolate row of four, cowering behind the waterproof aprons (which were not waterproof), and exchanging fragments of pessimistic philosophy. We knew we were taking cold; at first we were annoyed, but with increasing numbness came resignation. We grew calm enough to feel an interest in the imperturbable driver, who nonchalantly and with perfect technique steered his dogged horses through the tortuous mazes of traffic, never speaking, never stirring, only answering like an automaton to the conductor's bell. Some drivers will gossip, but this one had apparently his own preoccupations. We could see only his hat, some grey hairs, his rotund cape, and his enormous gloved hands; and perhaps we began to wonder what sort of man he was. For mile after mile he drove forward in Trappist silence, till we were verging upon Putney, and the rain-washed thoroughfares reflected only the gaslights and the forbidding *façades* of the houses.

Then at last, but without moving his head, he suddenly joined the conversation.

"I've been out in worse," he said. "Yes, we gets used to it. But we gets so that we *has* to live out of doors. If I got a' indoor job I should die. I have to go out for a walk afore I can eat my breakfast."

A pause, and then:

"I've driven these roads for eight-and-twenty year, and the only pal I've found is Cod Liver Oil. From September to March I takes it, and I never has rheumatism and I never has colds nor nothing o' that 'ere. I give it my children ever since they was born, and now I'm blest if they don't cry for it."

He finished; he had imparted his wisdom, delivered his message, and with the fine instinct denied to so many literary artists, he knew when to be silent. We asked him to stop, and he did so without a word. "Good night," we said; but he had done with speech for that evening, and gave us no reply. We alighted. The 'bus rolled away into the mirror-like vista of the street.—*Academy*.

From the Gazette's Special Pathologist.

B. B. G., Burton-on-Trent.—The wall of the abscess cavity consists of altered renal tissue. The glandular tubules have disappeared, but the fibroid glomeruli are embedded in fibrous tissue. There is no evidence of tubercle.

A. E. N., Bath.—The growth on blood-serum after incubation consists of staphylococci and a short diplobacillus. But the Klebs-Löffler bacillus was not found.

H., Ramsgate.—Tubercle bacilli are present in the sputum in small numbers.

W. S. F., Rickmansworth.—This tumour is chondro-adenoma of the parotid gland. It has undergone some amount of mucoid softening in the centre which gives it a cystic appearance. There is no evidence of its being malignant.

T. R. A., Clifton.—Tubercle bacilli are present in the sputum in small numbers. PATHOLOGIST.

Pneumothorax.

CLINICAL LECTURE By Dr. G. NEWTON PITT.
January 21st, 1899.

Gentlemen,—The case I propose to bring before you to-day is one of Pneumothorax. It is not a very common disease, and the fact that the symptoms are so striking and not infrequently occur in apparently healthy individuals, makes such cases specially interesting.

I have a long and very excellent report here by Mr. Swan, but I will merely give you the main points without going into too minute detail. The man is a gardener, twenty-three years of age, whose history is unimportant. He himself, until about nine months ago, enjoyed good health, since which time he has had, more or less constantly, cough and expectoration. He gradually became thinner and weaker, and in July went to an infirmary. He came out in September in very much the same condition. He then noticed that on the slightest exertion there was dyspnœa, and this has gradually increased. He has lost one and a half stones in weight, and has been sweating at night. He has been getting gradually weaker, and for the last fortnight he has frequently vomited; this has interfered very much with his taking any food, and has induced him to come into the hospital. There was no sudden onset of any symptom. He is an anæmic, emaciated man, has rapid breathing, 28 per minute, no great dyspnœa, and when at rest no very marked symptoms of distress.

On examination, it was found that the left chest was much more contracted than the right (this is due to old disease), and it moved less efficiently. On *percussion*, it was found that he had, in the front of the chest, a tympanitic area which extended as far as the right edge of the sternum, and from the first to the fifth rib. Over this area (see diagram 1) the note is tympanitic; over the rest of this side, below, there is dulness, with a more or less impaired note at the apex, but not quite so impaired as in the lower portion of the chest behind. The heart, it was found, had been pushed over to the right side, so that there was an area of cardiac dulness on the right side, commencing at the third rib, where it was partial, and at the fourth rib where the dulness was complete. The note over the rest of the right chest was apparently normal. It was also noticed that the liver was pushed two and a half inches below its normal position, the spleen was not palpable, and the stomach resonance extended up as far as the seventh rib.

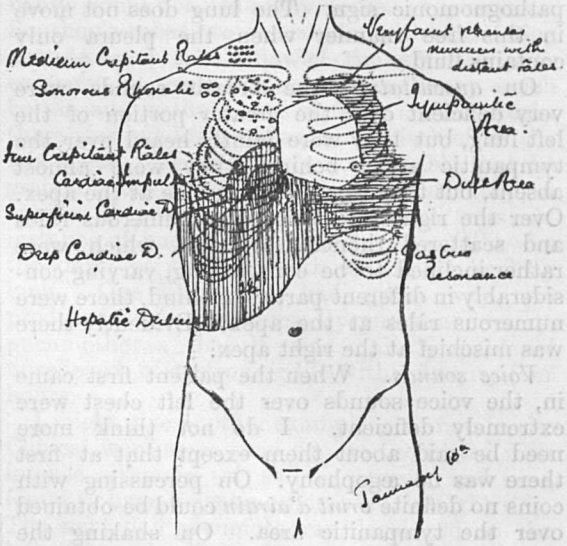


Diagram 1.

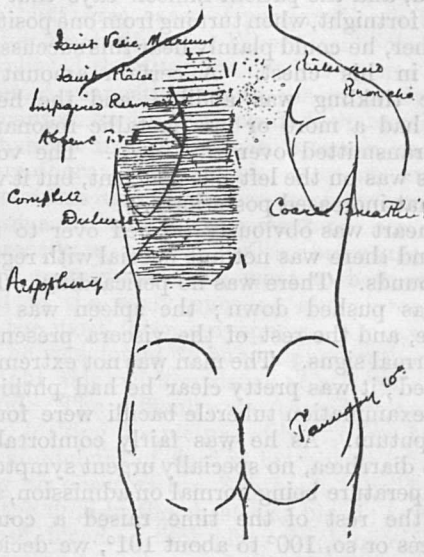


Diagram 2.

The most striking feature, therefore, was this tympanitic area in the front of the chest, when the patient lay on his back. It was found, however, that when he sat up, the tympanitic area appeared behind and above the scapula. When he turned on to his right side the tympanitic area was found in the left axilla, and when he lay on his face, the tympanitic area was between the scapula and the spine on

the left side. You have, then, a tympanitic area which very readily varies with the position of the patient, and that is a very important pathognomonic sign. The lung does not move in this free manner when the pleura only contains fluid.

On *auscultation*, the breath sounds were very deficient over the greater portion of the left lung, but they were faintly heard over the tympanitic area; behind, they were almost absent, but they were more audible at the apex. Over the right side there were numerous râles and scattered rhonchi, some of which were rather inclined to be consonating, varying considerably in different parts. Behind, there were numerous râles at the apex. Evidently there was mischief at the right apex.

Voice sounds. When the patient first came in, the voice sounds over the left chest were extremely deficient. I do not think more need be said about them except that at first there was no ægophony. On percussing with coins no definite *bruit d'airain* could be obtained over the tympanitic area. On shaking the patient a well-marked succussion splash could be heard, and the patient himself says that for the past fortnight, when turning from one position to another, he could plainly hear this succussion splash in his chest. A certain amount of metallic tinkling was audible, and the heart sounds had a more or less metallic resonance when transmitted over that area. The vocal fremitus was on the left side deficient, but it was somewhat increased posteriorly.

The heart was obviously pushed over to the right, and there was nothing special with regard to its sounds. There was no pericarditis. The liver was pushed down; the spleen was not palpable, and the rest of the viscera presented no abnormal signs. The man was not extremely distressed; it was pretty clear he had phthisis, and on examination tubercle bacilli were found in his sputum. As he was fairly comfortable, with no diarrhœa, no specially urgent symptom, the temperature being normal on admission, but during the rest of the time raised a couple of degrees or so, 100° to about 101°, we decided to leave the thorax alone and not to interfere at present.

The only alteration has been the diminution in size of the tympanitic area; and the development of ægophony; on the whole, the patient has remained fairly comfortable. Yesterday, ten days after admission, it was noticed that a further change had taken place in the physical signs (see diagrams 3 and 4). You can now trace the tympanitic area, one-half or one inch to the right of the sternum, and behind there was evidence that the fluid in the left base had pushed over the pleura into the right side, so that there was an area of dulness of an inch or

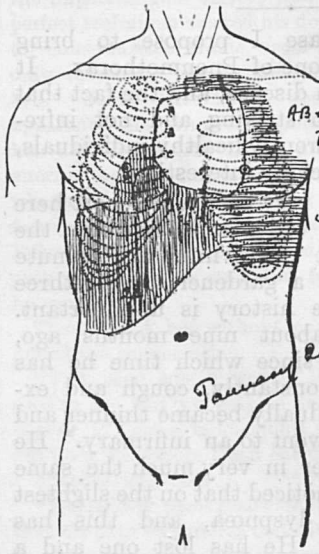


Diagram 3.

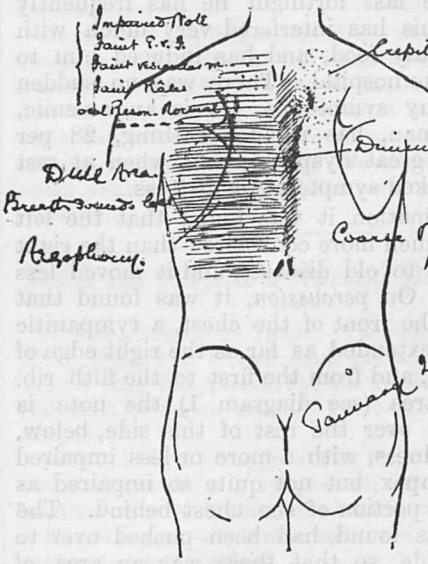
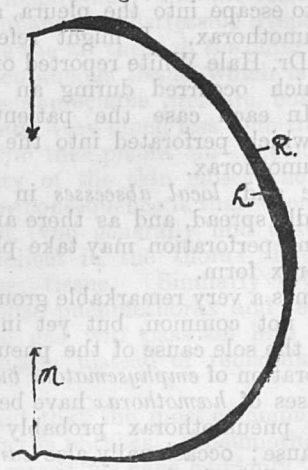


Diagram 4.

more on the right side of the spine behind; there was the evidence, therefore, that the fluid had increased somewhat, and the left pleura had certainly extended one inch into the right side of the thorax.

I wish now to draw your attention to the cyrtometer tracings. As a rule where you have an acute pneumothorax, the affected side is greatly increased. The outer margin of the thick line in the diagram indicates the healthy



Cystometer tracing at the level of the 7th dorsal spine reduced to $\frac{1}{4}$th.

Diagram 5.

side, and the inner the superimposed tracing of the affected side. In this case the affected side is considerably smaller than the healthy, the reason being that the man has chronic mischief in the left lung, which has become fibroid and is diminished in size; it is also because there is the extensive mischief in the left lung that his symptoms are so slight. I think, no doubt, the right side of the chest has been rather increased by the fact that the heart has been pushed into it, and that the left pleura now also extends to that side.

I might, before passing on to a general discussion, refer to a few other cases of pneumothorax, which I have come across within the last few years. As an antithesis to the case I am giving to-day, I should like to take the case of a young man about twenty-one years of age, whose sister had phthisis, and who beyond working somewhat hard and getting thin, had no very obvious acute illness, until one night he was seized with intense pain in his left chest, and within two or three hours he was gasping for breath, with the most intense dyspnœa, sitting up in bed in a cold perspiration and with the signs of mortal illness. When I came to examine him, I found he had a large pneumothorax on the left side, and the whole of the chest was motionless and so tightly distended that it gave an almost dull note. His distress was so rapidly increasing, that it was quite obvious, unless something were done, he probably would not live many hours. I inserted a Southey's tube into the axilla, with a dressing outside, and thus allowed the air slowly to escape; in the morning he was very much better, and in the course of three or four weeks there was but little evidence of mischief in the left chest. He was fairly comfortable, but he gradually developed phthisis, and died about a couple of years afterwards. There was an instance of pneumothorax in a young fellow at the onset of phthisis, with an almost healthy lung. One little spot had given way and produced such an intense dyspnœa and acute pneumothorax that it was quite capable, if unrelieved, of destroying life within twenty-four hours.

I might give another example. A man in the Clinical ward some time ago was admitted with intense dyspnœa of sudden onset, and was found to have a pneumothorax on the right side. The next day pneumothorax developed on the left side and he died. Suppurative mediastinitis was found, but its origin was obscure. We have had three cases of pneumothorax coming on after tracheotomy. Where tracheotomy has not relieved the dyspnœa but has opened up the planes of connective tissue, the great dyspnœa has caused air to be sucked down, setting up emphysema in the connective tissue, and fatal pneumothorax has resulted.

I saw this time last year a most remarkable case of a young man who went out for a walk apparently in perfect health, but came home with a pain in his chest, went to bed, and was found in the early morning almost moribund with the most intense dyspnœa. On examination, he was found to have a pneumothorax on the right side, with evidence of a large amount of fluid. The difficulty was to understand how a boy, looking the picture of health, could have such an amount of fluid in his chest. On aspirating his chest with a Southey's tube, I found that the fluid in the chest was blood; as the air escaped, bleeding took place much more freely, and it was quite obvious I should only accelerate his end if I continued to draw off any more. He died the same night, and I found a small prominent emphysematous vesicle with vascular adhesions which had ruptured and caused the patient to bleed to death. That was a most exceptional case.*

* Since this lecture was delivered we have had another case of pneumothorax in a small, very delicate boy of six. He had measles last November, associated with severe lung mischief, and has steadily become more septic, due

There are besides those already mentioned many different conditions which may be associated with pneumothorax.

131 CASES: ASSOCIATED CONDITIONS.

Phthisis, 81; empyema, 29; gangrene or abscess, 8; emphysema, 5; hæmothorax, tracheotomy, fractured ribs, punctured wound of chest; exceptionally cancer, sub-diaphragmatic abscess opening into bowel, typhoid, pertussis, œsophageal growth, and sometimes no cause has been determined beyond violent effort. There have been 23 cases of pneumothorax during the past thirteen years out of 6200 post-mortem examinations at Guy's Hospital, *i.e.*, 3·7 per cent. per 1000. There were 13 due to phthisis, of which 10 resulted from the opening of cavities, and three from sloughing over nodules of acute caseous broncho-pneumonia; three associated with emphysema of the mediastinum followed tracheotomy; two associated with subcutaneous emphysema followed fractured ribs; one was due to a ruptured bronchus; two to empyema; one to rupture of an emphysematous vesicle; and one to an infarction which had broken down.

First of all I have put down *phthisis*. Really the cases due to phthisis—I am excluding surgical cases—are probably much more than 70 per cent. of the total, because you will find that it is especially with phthisis that pneumothorax occurs with symptoms so slight that they are apt to be overlooked, and it is only in the early and more acute cases, where the symptoms are urgent, that attention is paid to them. So this probably is an under-estimate.

It is comparatively rarely that the wall of a chronic cavity bursts, for the cavity almost invariably has adhesions over it; but occasionally the pleura over a cavity or a caseous, pneumonic nodule, away from the apex, where it is not adherent to the chest wall, sloughs, and perforation takes place.

Empyema forms another group, and a most important one. With regard to empyema, the virulence—I mean the digestive capacity—of the organisms which set up the disease varies very much. In certain cases you find the organisms seem capable of readily digesting the epithelial surface, and the empyema bursts into the lung. You will sometimes find the track allows air to escape into the pleura, and so set up a pneumothorax. I might refer to two cases that Dr. Hale White reported of pneumothorax which occurred during an attack of typhoid. In each case the patient had an empyema which perforated into the lung and set up pneumothorax.

Gangrene and *local abscesses* in the lung. These rapidly spread, and as there are usually no adhesions perforation may take place and a pneumothorax form.

Then comes a very remarkable group of cases which are not common, but yet in which it seems that the sole cause of the pneumothorax is the perforation of *emphysematous bullæ*.

Some cases of *hæmothorax* have been said to produce a pneumothorax probably due to a common cause; occasionally also *cancer of the lung* and *subdiaphragmatic abscesses*. Most exceptionally, vomiting, coughing, and pertussis have resulted in rupture to the lung, and thereby set up pneumothorax.

I have put down, last of all, those cases which occur in apparently *healthy individuals* who by some violent exercise set up pneumothorax. These possibly are very closely associated with those due to emphysematous bullæ. Dr. Havilland Hall collected thirty-one published cases of apparently healthy individuals (twenty-nine out of the thirty-one cases were men) who, after some violent exercise, developed a pneumothorax. For instance, in one case a man tried to lean back and touch the ground with his hands, and a pneumothorax resulted. Such cases are difficult to explain whether we assume there were emphysematous bullæ, or whether they occur in individuals who have no actual disease. It should be remembered that if the imminent danger be tided over by aspiration, they generally recover completely.

Next come the surgical cases: a certain number occur on the surgical side of the hospital, but are rarely fatal. You find, first, cases of fractured ribs where the rib has lacerated the lung and thereby a pneumothorax has resulted; but pneumothorax as the result of such fractures is rare. There are a few cases where a bougie, passed down the œsophagus, has descended to the pleura; also cases where children have been run over and the bronchi have been lacerated.

I want, however, particularly to impress upon you that a wound in the chest does not, as a

to the foul condition of his sputum which he has invariably swallowed. When admitted he had evidence of bronchiectasis in the left lung and was extremely ill. After a few days in the hospital he was seized with intense pain in the left chest and became collapsed. A tympanitic area appeared at the apex, which did not become very tense and he died a few hours later. P.M. there was evidence of old fibroid changes in the left lung, with an acute necrotic pneumonia which had riddled the lower two-thirds with innumerable cavities, the pleura over several was sloughing, and at one spot an opening half-an-inch across was found. The respiratory movements on the left side had been so feeble that but little air had escaped into the pleura.

rule, set up a pneumothorax. A punctured wound of the lung almost always sets up a subcutaneous emphysema and not a pneumothorax. The air escapes from the lung into the pleura with inspiration; and the violent efforts which accompany the distressing dyspnœa that results, drive the air through the outer puncture into the subcutaneous tissue, which is not able to resist any appreciable pressure, but distends with a pressure very much less than that which is present in the pleura in pneumothorax. The elasticity of the skin closes the external opening. The consequence is that when the lung is punctured, you generally find that the air does not collect in the thorax, but in the subcutaneous tissue. Similarly when you aspirate a tense pneumothorax and remove the cannula, the gas will pass on into the subcutaneous tissue instead of remaining in the thorax.

I have said that the most common cause of pneumothorax is phthisis. Pneumothorax is a very rare disease; we have had only 23 out of 6200 post-mortems, *i.e.* 3·7 per 1000. It is difficult to say what is the proportion of cases to those of phthisis. Some writers put it down as from five to ten per cent., but the probability is that it is very considerably under five (I find out of 521 cases of phthisis fatal at the hospital, 13, *i.e.*, 2·5 per cent. had pneumothorax).

It is curious that the proportion of cases in men is far larger than that in women; this is possibly due to their greater vigour of respiration. The lesion generally occurs in young people. A few cases occur in middle-aged persons, but the mean age is under thirty. Most authorities state that the left side is much more frequently affected than the right; Dr. Fagge, however, found 26 cases at Guy's equally distributed on the two sides.

I will now discuss one or two questions with regard to the POST-MORTEMS. A small pneumothorax is very apt to be overlooked. If you open the thorax in the ordinary way, you may pass it over entirely. If you are in any doubt, the best way, after separating the skin, is to pour a small quantity of water into the space between the ribs and skin flap, and to puncture one of the intercostal spaces over the tympanitic area through the water, and see whether air bubbles escape. In that way, you can make quite certain whether or not the case has been one of pneumothorax, and unless you do that you may overlook it. Another way which is sometimes useful is to shake the body. If there is a pneumothorax, you will froth up the fluid inside, which would not be the case supposing there was only fluid without gas.

The seat of perforation is very rarely at the apex. It is most commonly at a lateral portion of the lung, away from the apex somewhere between the adjacent surfaces of the upper and lower lobes. The aperture varies; sometimes where an abscess has sloughed it is large enough to admit a finger. In other cases you find a small valvular opening which, during inspiration has allowed the air to pass through into the pleura, but does not allow it to return. It is in these cases when respiration is vigorous, that the pleural pressure rapidly increases, and immediate relief is necessary. There are others, where the lymph poured out over the surface makes it extremely difficult and sometimes impossible to find the aperture. In most cases there is lymph with serous or purulent fluid collected in the cavity. Sometimes the amount is very large indeed. You may sometimes, on account of the absence of dyspnœa perhaps, and neglecting the displacement of the viscera, allow a large amount of fluid, about three or four pints even to pass undetected, not appreciating that such an amount may be present.

As a result of increased pressure, the lung is often very compressed. As to the nature of the gas, if the mischief has lasted any time, it generally consists of nitrogen; the oxygen and carbonic acid having been absorbed. In some few cases hydrogen is also present. With regard to the pressure in pneumothorax, it will vary from nothing up to nine inches of water on inspiration; and on expiration it may even run up to thirteen inches. The difference of pressure in inspiration and expiration varies. In such a case as we have to-day, where the respiratory movements are very feeble on the left side—and this is one of the reasons why the patient's condition remains quiescent—there is but little difference between the pressure on inspiration and expiration. But where you have a healthy person who has very intense dyspnœa, you may have a difference of some inches.

SYMPTOMS.—The cases may be divided into those with an acute and urgent onset, and those in which the onset is insidious. In fact, sometimes there are no symptoms whatever; our present case is an example, pneumothorax was not suspected until after physical examination.

Dyspnœa. — Where much lung tissue is diseased, and it is more or less solid, the symptoms may not be marked. The most urgent cases are those in which the greater portion of the lung is healthy, and in which there is no apparent disease. Such a person will

probably have complained of more or less pain (in a phthisical case at any rate) in the chest for a few days. But the onset is sometimes quite sudden, as though something had torn and given way, with agonising pain, and dyspnœa which rapidly becomes intense. The patient soon becomes cyanosed, cold, and collapsed, with a subnormal temperature and a rapid pulse and respiration. The condition may be such as to cause death within a few hours.

In many cases some special effort has caused the actual rupture. In Dr. Hale White's cases to which I have already referred, both occurred as the result of straining at stool. In most cases an effort precedes the onset, but in our case the onset was insidious, we cannot fix a date.

PHYSICAL SIGNS.—These vary in different cases. In acute cases you find that the affected side is very much over-distended and there is very little respiratory movement, the spaces become obliterated, and the heart, liver, and spleen, displaced. Where the air accumulates on the left side the cardiac dulness is transferred to the right. In chronic cases you may find no evidence of extreme distension; on the contrary, there may be contraction due to preceding disease.

On percussion there is a tympanitic note over the area where the gas has accumulated. But with an acute pneumothorax which is distending the whole of one side of the chest, the tympanitic note will vary as the tension increases, becoming less and less obvious until when the tension is extreme, there is almost complete dulness. You should bear this in mind, because sometimes it is rather deceptive. In a localised pneumothorax the note varies with the position of the patient.

The alteration in the *breath sounds* is variable. They may be absent, but by no means is that necessarily the case, more often the breath sounds are distant and deficient. In some cases there is amphoric breathing, in others merely a transmission of râles or rhonchi which take on a clear, sharp, metallic note (*metallic echo*). I think it is quite certain that where there is amphoric or tubular breathing, it does not necessarily imply a large aperture through which air is passing in and out of the lungs into the pleura, but that the sounds may be transmitted from the adjacent lung. In favour of this theory is the fact that, as in this patient, the heart sounds over the cavity are heard with a metallic clang, quite different to the normal heart sounds. Then, of course, you often have signs of fluid accumulating in the pleura below where the air first collects. In many cases you hear *metallic tinkling*, which used at one time to be thought to indicate the dropping of fluid from the wall of the cavity into fluid below. There seems a good deal of evidence, however, in favour of the belief that these sounds may simply be râles in the lung which have a metallic resonance owing to their being conducted through an air cavity.

The *succussion sounds;* when you can obtain them, are pathognomonic of a large cavity containing a mixture of fluid and air, and are very often noticeable by the patient quite as readily as by the observer. Mr. Swan has also pointed out to me to-day, in our patient, that if you put your finger over the tympanitic area and shake the patient, you can feel the impact of the wave of fluid.

The *voice sounds* also may vary. In some cases they may be diminished, in others you hear bronchophony, and occasionally ægophony; there is no very definite rule. You do not obtain any vocal fremitus over the air cavity.

Taking the symptoms as a whole, the ones on which you should lay the chief stress are: metallic echoes of râles, voice or heart sounds, amphoric breathing and succussion splash. These are all indicative of pneumothorax, and though not always all present, some are certain to be. There will also be a tympanitic note over the same area.

TREATMENT.—You want to distinguish, first of all, the acute cases, where the distress is so great and the urgency so extreme that you must do something at once. I think that by far the best treatment in these cases is to sterilize the skin, leave in a Southey's tube, and apply an antiseptic dressing over it, thereby allowing the air to escape gradually as it accumulates in the chest. In that way you find you do not distress the patient at all, and gradually, as the air is pumped into the pleura, it is allowed to drain out into the dressing. Often this method is attended with very satisfactory results.

The distress and collapse may be so urgent that you must give stimulants and morphia to relieve the intense pain, and to diminish the activity of the breathing, because the intensity of the dyspnœa depends largely on the vigour of the respiration, and if you give an injection of morphia and prevent the patient from breathing so vigorously, you will relieve the dyspnœa. The urgency of the dyspnœa, besides being due to the vigour of the respiration, partly depends on the size of the perforation and its relation to the bronchi, and more particularly whether the aperture is valvular. Where

you have a fairly large aperture, say, a quarter of an inch across, the air will go in and out and the pressure will not rapidly increase. But where you have a perforation which is more or less valvular, which opens and shuts, there you have a condition which rapidly produces great distress: so this also determines the urgency of the dyspnœa. If you have a healthy lung, it collapses extensively, but where you have adhesions, the amount of the collapse is comparatively small; this is the third factor.

Having relieved the immediate urgent distress, you have, according to the cause, to decide on further treatment. Pneumothorax may occur in apparently healthy people who will in many instances recover and require no further treatment. But, on the other hand, if you have an empyema you should at once open the chest as there is nothing to be gained by waiting. By opening the chest at once the probabilities are that the patient will recover completely. If, however, you have a phthisical case, if the patient is comfortable, the dyspnœa not very great, and there is evidence of a good deal of mischief in the lung, as is usually the case when there is not much dyspnœa, the probability is that you may with advantage wait. But should you find evidence of rapidly increasing fluid, or should the patient rapidly become anæmic and emaciated and suffer from diarrhœa, you must interfere and drain; but do it with the distinct idea that the wound will probably never close up again, and there will be a permanent fistula.

In tuberculous cases you will often find that the less active your treatment the better, because if you have a permanent wound which requires daily dressing it adds very considerably to the discomfort of the patient. But sometimes it is absolutely necessary that you should drain. If, however, there is no evidence of any progressive spread of the fluid do not be active.*

CONDITIONS WHICH ARE LIABLE TO BE CONFUSED WITH PNEUMOTHORAX.—First of all, are those which present similar physical signs, as, for instance, a *subdiaphragmatic abscess which contains gas*. It is by no means easy to separate a subdiaphragmatic abscess from a pneumothorax. I might refer to the case of a boy who came into the hospital with gas contained in a cavity, and on percussing over his liver area, it was found, as he lay on his back, to be absolutely tympanitic, and there was no dulness at all. On turning the boy over on to his right side, the liver dulness seemed to come up again to the chest. It appeared to be a case in which there was a subdiaphragmatic abscess containing gas, and as you moved the boy about, the liver came up or fell away from the chest wall. Upon exploration, to our astonishment, we found the collection of gas was entirely above the diaphragm, and the mistake arose from the fact that when there is a collection of gas immediately in contact with the liver, the note given over the the liver, on percussion, may be tympanitic instead of dull. The same condition occurs sometimes in connection with a subdiaphragmatic abscess which contains gas adjacent to the heart. On percussing over the cardiac area you may find it tympanitic. You would naturally say there must be a pneumo-pericardium, and yet you might be in error. I think we must accept the fact that gas tensely contained in a cavity, adjacent to a solid body, may give rise to a resonant note over that solid body. It is very remarkable, but there is no doubt about the fact. So in this boy, it was quite clear that the liver was in contact with the diaphragm, and did not move in the slightest as the boy altered his position, and the hepatic note was determined by the position of the gas in the pleura; therefore you may have very considerable difficulty in determining between a subdiaphragmatic collection of gas, and one above the diaphragm, and in that case, it was only after an operation that we came to the right conclusion.

You may also have difficulty in deciding whether you have a large cavity in the lung; but, as a rule, if it is a large *tuberculous cavity* it is at the apex; whereas it is comparatively rare to find a localised pneumothorax there. If the cavity is due to *bronchiectasis* you have probably obtained a history of lung mischief dating over many months, and the associated condition will generally enable you to come to a correct conclusion. But there are occasionally cases where it is quite uncertain whether you are dealing with localised pneumothorax or bronchiectasis. A *ruptured diaphragm* with a hernia of the intestines is usually the result of a severe crush.

In cases of *emphysema*, you may obtain such a tympanitic note, that you think you must be dealing with a pneumothorax. The area is always bilateral, whereas a pneumothorax always starts on one side, though it may occasionally become bilateral. So that you should be able by that means to distinguish between the two.

These are the most common important conditions which present somewhat similar physical signs. With regard to other conditions which

*Out of 48 cases in the medical wards in twelve years 18 died and the remaining 30 went out more or less relieved.

may present similar symptoms, the most important is *pulmonary embolism.* You can only distinguish it from pneumothorax by the physical examination.

Obituary.

Robert Fenton Macdonald.

Died February 2nd, 1899.

It is with the deepest regret that we have to announce the death of Robert Fenton Macdonald, aged 17. He was taken ill last week with what was thought to be indigestion, but which subsequently appeared to be appendicitis, and he was brought up to the hospital on Thursday morning, then in a very serious condition. He was too collapsed to be operated on, and died a few hours after admission from general suppurative peritonitis. He was educated at the Bancroft School, at Woodford Wells, and matriculated at the London University in July last, taking second place in the honours list. He gained the Guthrie Entrance Scholarship at Westminster, but resigned it upon winning the £100 Arts Entrance Scholarship here. Whatever he took up he did well, and his untimely death has cut short one of the most promising careers among the junior men.

Royal College of Surgeons of England.

Syllabus of Three Lectures on "Researches on the Influence of Gravity on the Circulation," to be delivered in the Theatre of the College, on Monday, Wednesday, and Friday, February 6th, 8th, and 10th, at five o'clock each day, by Professor Leonard Hill.

LECTURE I. (Monday, February 6th).—Our knowledge of the subject in 1894.—*Origin of the present enquiry.*—The method of research.—Criticism of the method of Hermann.—Comparison between a distensible and a rigid schema.—The normal effect of posture on arterial and venous pressures.—The record of (*a*) carotid and jugular, (*b*) femoral, (*c*) splenic, (*d*) cerebral pressures.—The effect of posture after division of (*a*) the splanchnic nerves, (*b*) the spinal cord.—The result of clamping the vena cava inferior.—The effect of exciting the depressor nerve.—The effect of exciting the vagi.—The mean pressure of the vascular system.

LECTURE II. (Wednesday, February 8th).—The influence in the vertical and horizontal postures of (*a*) the normal respiration, (*b*) artificial respiration.—The effect of curare.—The results which follow compression of (*a*) the abdomen, (*b*) the thorax.—The rôle of the pericardium.

A comparison between the influence of gravity on the circulation of the monkey, dog, cat, rabbit, hen, snake, frog, eel.—Concerning the tense and patulous abdomen as found in wild and hutch rabbits.—The production of syncope in rabbits.—The effects of baths.

LECTURE III. (Friday, February 8th).—The effect of gravity on the circulation of Man.—Method of research.—The influence of the venæ comites upon the radial artery.—The correct measurement of arterial pressure in Man.—The effect of posture on arterial and venous pressure, and on pulse-frequency.—The influence of work, rest, sleep.—The causation of sleep.—The influence of anæsthetics.—The causation of chloroform-syncope.—The relief of syncope.—The influence of posture on conditions of shock and anæmia.—The causation of emotional syncope.—Of death from crucifixion.—On the general relation to the circulation of the respiratory-pump and the skeletal muscles, and the value of exercise.

EDWARD TRIMMER, Sec.

Christmas Test Examinations.

PRELIMINARY SCIENTIFIC (M.B.) CLASSES.

CHEMISTRY.—PHYSICS.

CHRISTMAS, 1898.

Maximum in each subject 100.

J. H. Clatworthy	67	H. H. Carter	72
R. F. Macdonald	62	R. F. Macdonald	70
M. G. Louisson	61	R. Felton	62
W. P. Purdom	58	J. H. Clatworthy	58
G. Hamilton	57	A. M. Roome	50
R. Felton	55	G. Hamilton	49
H. H. Carter	53	R. Leeming	49
R. O. Williams	53	M. G. Louisson	49
L. Doudney	51	R. O. Dowdeswell	47
C. H. Reinhold	51	C. H. Reinhold	46
A. M. Roome	47	R. O. Williams	45
E. L. R. Norton	46	L. Doudney	43
O. Sinclair Norton	45	E. L. Norton	36
R. O. Dowdeswell	44	W. P. Purdom	33
A. Leeming	35	O. Sinclair Norton	33
G. Russell	*20	G. Russell	*13
J. O. Musson	*13	A. B. O'Brien	*12
A. B. O'Brien	*13	J. O. Musson	*5

*Absent from written examination.

EXAMINATION IN ANATOMY: FIRST YEAR'S STUDENTS.

CHRISTMAS, 1898.

E. H. B. Milsom	98	B. Glendining	54
P. R. Bolus	97	C. E. Iredell	54
N. I. Spriggs	95	C. R. Shattock	53
A. M. Webber	89	F. Barnes	51
H. S. Brown	77	G. L. Buckeridge	49
G. Carlisle	77	C. J. Pinching	47
R. Larkin	77	H. B. German	47
W. F. Box	76	F. G. Goble	46
F. W. Fawssett	74	E. H. Griffen	46
F. Rogerson	73	R. G. Anderson	44
S. C. Bowle	71	A. Drewitt	44
C. D. Pye-Smith	70	L. Cooke	43
K. Black	67	H. O. M. Beadnell	39
O. B. Travers	64	J. W. Featherstone	39
W. L. M. Day	62	J. J. Gardiner	37
L. S. H. Glanville	61	E. J. Malim	37
H. D. Smart	61	R. M. Rendall	36
P. C. V. Bent	60	W. S. Orton	35
B. W. Lacey	60	C. A. Watson-Smyth	29

B. H. Wedd	60	R. D. Bridger	27
A. E. F. Kynaston	59	R. Franklin	26
C. F. Fraser	59	C. W. R. Preston	24
P. A. Peall	59	V. Goulding	15
G. H. Rees	59	H. M. Langdale	13
H. Watts	58		

ELEMENTARY ANATOMY EXAMINATION.

The following (3) students have passed the above examination:—

J. W. Caton. F. W. Cooper. H. Johnson.

CHEMISTRY EXAMINATION; FIRST YEAR'S STUDENTS.

Maximum 100.

L. Cooke	68	R. M. Rendall	52
S. C. Bowle	63	V. Goulding	49
G. Carlisle	61	C. A. Watson-Smyth	49
J. F. Rey	58	R. D. Bridger	48
F. Barnes	57	E. J. Malim	48
B. W. Lacey	56	W. S. Orton	47
H. M. Langdale	55	C. F. Fraser	45
R. G. Anderson	52	F. G. Goble	44
H. B. German	52	C. W. R. Preston	42

HISTOLOGY EXAMINATION.

CHRISTMAS, 1898.

Messrs. J. B. Copland, G. C. Lowe and I. S. Sheffield have passed the above examination.

EXAMINATION IN ANATOMY; SECOND YEAR'S STUDENTS.

CHRISTMAS, 1898.

E. Faulks, N. N. A. Houghton, W. G. Parker, A. H. E. Wall	87	C. H. Denyer	54
		H. S. Jones	54
		W. W. C. Jones	53
		P. W. Hamond	50
C. H. Robertson	86	G. F. Humphreys	50
W. E. J. Tuohy	85	A. P. Piggot	50
R. C. Lawry	83	W. C. Lewis	49
C. H. Bubb	83	E. G. Goldie	48
G. S. Robertson	82	A. H. Turner	46
J. Braithwaite	79	E. W. Strange	45
J. T. Hicks	75	R. Willan	40
H. T. Palmer	73	H. A. Cutler	39
T. Morland Smith	73	G. Moir	37
H. C. C. Mann	70	J. D. Pearson	37
A. W. Iredell	69	A. J. Beadel	33
M. C. Wetherell	66	C. M. L. Cowper	33
H. Tipping	63	E. N. Jupp	33
R. E. Brayne	59	H. R. Grellet	32
S. L. Pallant	59	C. E. Adams	31
P. P. Cole	58	F. P. Hughes	27
H. M. Goldstein	57	F. J. Turner	23
L. H. Moiser	57	C. A. E. Ring	13
R. T. Collins	56	W. H. Bush	12
J. W. Gromitt	55	R. C. Poyser	12
E. Couchman	54	L. O. Card	0

PHYSIOLOGY EXAMINATION: SECOND YEAR'S STUDENTS.

CHRISTMAS, 1898.

Full marks, 60.

W. E. J. Tuohy	46	G. Moir	29
J. T. Hicks	45	S. L. Pallant	29
P. P. Cole	41	J. D. Pearson	28
E. W. Strange	40	W. G. Parker	27
C. H. Bubb	39	R. Willan	27
C. H. Robertson	38	E. Faulks	26
N. N. A. Houghton	37	H. Tipping	26
L. G. Nash	37	H. A. Cutler	24
H. T. Palmer	37	W. W. C. Jones	23
M. C. Wetherell	36	A. J. Beadel	22
T. Morland Smith	35	R. E. Brayne	21
E. G. Goldie	34	R. T. Collins	21
A. W. Iredell	33	E. Couchman	21
R. C. Lawry	33	E. N. Jupp	19
A. P. Piggot	31	W. C. Lewis	19
P. W. Hamond	30	C. M. L. Cowper	18
H. C. C. Mann	30	G. F. Humphreys	18
G. S. Robertson	30	R. C. Poyser	18
A. H. E. Wall	30	C. E. Adams	17
J. Braithwaite	29	F. P. Hughes	17
C. H. Denyer	29	A. H. Turner	15
H. M. Goldstein	29	F. J. Turner	10
J. W. Gromitt	29		

ANATOMY EXAMINATION FOR FIRST YEAR'S DENTAL STUDENTS.

CHRISTMAS, 1898.

Maximum marks, 80.

A. Battersby	55	K. C. Ness	32
E. W. Corfe	55	H. R. C. Butler	22
H. J. Webb	53	E. J. Gaffney	32
G. H. Aylen	51	H. N. Hillier	32
H. L. Dent	49	J. Bennett	31
H. B. Ross	48	O. H. Dignum	31
J. H. Hinton	47	P. E. Coish	30
W. E. Meads	47	P. H. Furnivall	30
C. S. Morris	45	J. F. Rey	30
D. H. Wallis	45	A. M. A. Stevens	30
G. W. Ray	43	J. W. Powell	29
T. Robinson	43	A. W. Aldis	28
J. L. Wartski	43	P. Greenwood	28
J. J. Jiménez	42	V. E. Turner	28
A. R. Cummings	41	N. W. Green	27
C. Hickes	40	G. F. Knowles	24
W. R. Searle	39	A. Archer	20
F. W. Bromley	38	R. S. Witcomb	20
V. S. Sams	38	S. E. Pedler	10
A. H. Smith	38	E. G. Smith	7
H. S. Wright	38	W. K. Perry	3
F. Morris	35		

ANATOMY EXAMINATION FOR SECOND YEAR'S DENTAL STUDENTS.

CHRISTMAS, 1898.

F. Warlow	92	F. J. Pearce	42
A. E. Rowlett	86	C. F. Rose	42
R. J. Morrell	76	L. Webb	40
W. H. Tattersfield	74	E. C. Bartlett	36
J. Black	67	G. P. Pollitt	36
F. W. Garman	65	J. S. Biss	36
R. Peacock	65	J. H. Wilkes	35
R. B. Recordon	64	S. J. St. H. Tweney	34
P. H. Hayes Palmer	62	R. W. Allen	29
R. C. G. May	60	E. B. L. White	29
J. A. Whittington	59	A. M. Gabriel	25
H. Maurice	56	A. C. Edwards	24
G. H. Drake	55	N. P. Shepherd	23
E. R. Howlett	52	S. H. Jones	23
J. B. Morrish	51	J. H. Greenwood	21
H. T. Campkin	50	A. E. Wood	14
A. H. Saunders	49	H. Hatton	14
F. R. Coish	45	W. Jarvis	8

Sport.

Rugby Football.

GUY'S v. ROSSLYN PARK.

This match was played at the Old Deer Park, Richmond, on Saturday, January 21st, under somewhat unfavourable weather conditions, as there was half a gale blowing straight down the ground. Guy's put a strong team in the field, Sime, who was playing in the Scotch International Trial game, being the chief absentee, while O'Brien had sufficiently recovered from his injured clavicle as to permit of his re-appearance as centre three-quarter.

Losing the toss, Guy's kicked off against the wind, and play immediately centred in our twenty-five, but the forwards soon cleared their goal-line, and, keeping the ball well under control, worked it to the other end of the field. Rosslyn Park took full advantage of the wind by good kicking, and so kept off the attack for some time; but O'Brien, taking a pass from Wetherell, cleverly got through the opposing three-quarters, and gave a well-judged pass to Pye-Smith, who, when right on the line, transferred to Hilton, a well deserved try resulting. Thomas took the kick, but could make little impression on the wind, the ball being blown back from the posts. The home side got a long kick in from the twenty-five line, but Pye-Smith returned well, and good tackling by Cutler kept the game in the Park quarters, until Evans failed to judge a long punt, and a touch down resulted. The opposing three-quarters now got in a good bit of passing, but Jackson tackled in fine style, and spoilt their efforts. Guy's were again compelled to touch down, and Rosslyn Park marked the kick-out at the half-way line; from here they essayed a kick at goal which only failed from want of elevation, the ball going under the cross bar. O'Brien dropped out, and Lawry, by good backing up, secured the ball, and made a useful punt into touch. Guy's now kept the game tight, and worked the scrums effectively, while Pye-Smith, intercepting a pass, transferred to Thomas, who, however, did not hold it, and half-time found the game in mid-field without further score.

Considering the success of their efforts against the wind, Guy's supporters expected them to knock up points with its assistance, but the home side played up with much dash, and were fully able to cope with the somewhat disorganised attack of the hospital forwards, many of whom were too intent on scoring to think of lending the scrum their weight. For some time, indeed, play was in our twenty-five, but the efforts of Mullins, Lawrie and Manson worked the ball down to the home lines, where a score was lost by too hard kicking. Cutler tried a drop at goal, but the ball went low. Wetherell was now disabled for some minutes, Cutler acting as his substitute, the former on his return went very lame, and the Park halves began to act on the offensive, assisted by their pack, who, for a time, got the best of the scrums; they kicked over our line, but only a touch down resulted. The Hospital forwards now woke up a bit, and transferred play to their opponents' quarters, and Jackson found touch near the corner flag; scrums resulted five yards from the line, but Rosslyn Park cleared well, and again invaded our twenty-five. A nice piece of work by the centres was spoilt by Rae failing to take a pass from Pye-Smith, and a good opening was lost; Manson got clear away from the scrum, and dribbled well down the field, once more the ball was passed across the three-quarter line, but fumbled by Rae on the wing. No-side was called immediately after, and a well-contested, but, from a Guy's point of view, somewhat disappointing game ended in our favour. Score: 1 try to nil.

REMARKS.—Evans was never very hard pressed, but played a sound game throughout, as did both centres, some of Pye-Smith's openings being very well made; Rae was decidedly off colour, fumbling badly on more than one occasion. The halves both played well, Jackson's tackling being especially deadly. The forwards showed a great lack of finish in their game, and Mullins had frequently to call for more work in the scrimmage, while the packing was very uneven, and in the second half the front rank got none too much of the ball. Unanimity among the forwards is the secret of success in their department of the game, and we trust that this will be their aim when it comes to the cup-ties. Mullins and Trail played their usual sound game, while Manson and Lawry also played up well; some of the others appeared to be having an off day. Team:—

GUY'S.—G. Evans (back); C. T. Hilton, —. Pye-Smith, —. O'Brien, F. L. Rae (three-quarter backs); M. C. Wetherell, F. D. S. Jackson (half-backs); R. C. Mullins, D. Traill, A. A. Ayre-Smith, H. A. Cutler, P. Manson, A. H. Wall, R. C. Lawry, T. P. Thomas (forwards).

GUY'S "A." v. REDHILL AND REIGATE.

This match was played at Redhill on Saturday, January 28th, and after a pleasant game, resulted in a win for Guy's by 1 penalty goal (Jarvis) and 1 try (Evans) to 1 try.

The ground was in a very bad condition. Play was of a very even character during the first half, neither side being able to score. Jarvis' tackling at centre three-quarter was excellent. After half-time Guy's were at first pressed, Redhill being allowed to score owing to feeble tackling. Later, after some good play by Pye-Smith and Pearce, Evans scored; the kick failed. Continuing to press, the Hospital was awarded a free kick in front of goal—Jarvis was successful with the kick.

Hicks at half played well throughout, Malin should learn to pass more. Anderson played a very keen game forward. As we play Wimbledon in the first round of the Surrey Cup on Saturday, February 18th, it is to be hoped that Pearce and the rest of the team will train regularly during the next fortnight. Team:—

GUY'S.—E. N. Jupp (back); J. H. Wilkes, C. D. Pye-Smith, W. Jarvis, F. J. Pearce (three-quarter backs); J. T. Hicks, E. J. Malin (half-backs); R. C. Lawry, E. H. B. Milsom, A. R. Thompson, B. Glendinning, D. P. Watson, M. A. Collins, R. G. Anderson, G. Evans (forwards).

GUY'S 3RD XV. v. SOUTHWARK "A."

Played at Kidbrook and resulted in a victory for us by two tries to nil. Guy's elected to play against the wind in the first half, and were on the defensive most of the time, but the safe tackling of our backs prevented Southwark from scoring. On changing over with the wind in our favour the game became very even. Jarvis dribbled over and opened the scoring, but owing to the strong wind Bridger's attempt to convert was unsuccessful. There was no further score till just before time, when Greenfield broke away with a fine dribble, and scored behind the posts. Owing to a misunderstanding with the referee, the kick at goal was not taken. Team:—

GUY'S.—R. D. Bridger (back); O. Travers, C. Cowper, W. Jarvis, C. A. E. Ring (three-quarter backs); A. E. Kynaston and B. W. Lacey (half-backs); W. W. Jones, O. H. Dignum, D. G. Greenfield, —. Watts, —. Perry, —. Anderson, —. Rendall, W. I. Spriggs (forwards).

REMARKS.—The forwards followed up and tackled well, but their heeling was faulty, and they should learn to drop the ball quicker on getting it from a line-out. The halves played well together, but were handicapped by the bad heeling of the forwards. The three-quarters tackled well, but their passing was very faulty. Bridger played a grand game at back, his kicking and tackling being a feature of the game.

Association Football.

GUY'S v. IPSWICH.

This match was played at Ipswich on Saturday, January 28th, and resulted in a win for the Hospital by 3 goals to 2. We were without Wiltshire as he was playing in the Amateur Cup. The ground looked in excellent condition, and quite came up to one's expectations, proving to be both fast and true. Guy's won the toss and decided to play with the wind; both sides soon settled down, the game being very fast, at first one side and then the other pressed, but no real advantage was gained by either. Both goal-keepers were called upon to save more than once, Smith on one or two occasions doing so very smartly. Guy's now had rather more of the game, and from a low shot by Manser, the first goal was scored. The game now became of a more even nature, but very slow indeed, neither side seeming to exert themselves at all. Towards the end of the first half, owing to a misunderstanding between the referee and the linesman, Ipswich obtained a goal, the ball at the time being out of play. Nothing further resulting, half-time arrived with the score of one goal all.

On starting again the game once more became very fast, neither side being able to make an opening, the defence of both teams playing well. At length, however, owing to the Ipswich goal-keeper not clearing properly, Guy's obtained the lead, Norton heading the ball through. Ipswich now did a lot of attacking, and eventually equalised by a very hot shot. Just before the call of time, Manser obtained the third goal by a very good shot. Guy's thus won a good game by 3 goals to 2.

Smith in goal has much improved since the commencement of the season, but is still unsafe at times. Both backs played well, especially Robson, his kicking at times being distinctly good. The halves worked hard and did much towards the final result; German must learn to feed his forwards a little better. Manser and Norton were the pick of the forwards, Dent played well on the wing considering he usually plays inside. Team:—

GUY'S.—F. M. V. Smith (goal); W. M. Robson, N. P. Shepherd (backs); R. W. B. Hall, H. B. German, J. M. Brydone (half-backs); F. Morris, L. Norton, F. R. Manser, H. K. Lacey, H. L. Dent (forwards).

GUY'S HOSPITAL v. CHARING CROSS HOSPITAL.

INTER-HOSPITAL CHALLENGE CUP (2nd Round).

This Tie was played at Honor Oak on Wednesday, Feb. 1st. We were again without Wiltshire, who we hear will not be able to play for two or three weeks owing to an injury received on the previous Saturday, and Manser at the last moment had to scratch owing to illness. The ground was in a most deplorable state, fortunately there had been no rain for a day or two or else it would have been quite unfit to play on. The game from start to finish was very feeble, there being little or no attempt at combination, but individually at times the men were good. In the first half Guy's did most of the pressing, but several opportunities were lost owing to the bad shooting of the forwards. Both sides obtained several corners but nothing resulted from them. Towards the end of the first half Hall put in the only decent shot, but this the Charing Cross goal-keeper saved in fine style, thus at half time no goals had been scored.

In the second half Guy's had more of the game than in the first half, which was a little more interesting as both teams seemed to put more "go" into it. Our shooting also was much better, several good shots being put in which the goal-keeper saved. At length Hughes opened our account with a good shot. Soon after the goal-keeper in saving a shot only partially cleared, thus allowing Morton to obtain a second goal. Shepherd obtained the third goal from a long shot which hit the cross-bar and bounced into the goal.

Our opponents were never really dangerous in this half until nearly on time, when from a rush they obtained their only goal. Soon after, time was called, Guy's thus winning a very disappointing game by 3 goals to 1. The backs played well, Robson having distinctly improved since last year. The halves worked hard and did their best for the forwards, Hall played better than we have seen him for some time, he kept his place and marked his men better. The forwards gave a very poor show, Hughes and Norton being the best, the latter must feed his wing man more. Team:—

GUY'S.—F. M. V. Smith (goal); W. M. Robson, H. B. German (backs); R. W. B. Hall, N. P. Shepherd, J. M. Brydone (halves); P. S. Mandy, H. C. Dent, A. Hughes, C. Norton, F. Morris (forwards).

GUY'S 2ND XI. v. EVERSLEIGH.

This match was played at Balham on Saturday, January 28th, and resulted in the defeat of Guy's by 4 goals to 3.

Contrary to expectations, the ground was in good condition, and a fast and enjoyable game ensued. Guy's kicked off uphill and against the wind, and after a few minutes' play in midfield the home goal was attacked and an appeal for a goal was disallowed. Our forwards played a good combination, and a very fine piece of passing ended in Camps scoring our first goal by a fast shot from the right wing. Eversleigh then woke up, and our defence was hard taxed. Chiefly owing to their halves being entirely unmarked the game was for the most part in our half, and Eversleigh equalised with a good shot from the wing. Three more goals were scored against us before half-time, two on account of taking the man instead of the ball in front of goal.

On re-starting downhill a great change came over our play, and their goal-keeper was kept very busy. Several corners were ceded, but nothing resulted from them. Our shooting was very good, but ill-placed, Roberts and Peall both hitting the goal-keeper when at close quarters. The pressure was kept up, and a second goal was added, followed shortly by a third from Roberts, who was let through easily. Many good shots were put in, but were saved really brilliantly, and Guy's were unable to equalise. The game was a thoroughly well contested one, our forwards showing plenty of dash, which is sadly needed. The combination was at times good, Langdale's passing being very accurate, he being a decided acquisition to the team. Turner made a welcome re-appearance at back, filling the vacant position well. Altogether the team seems decidedly stronger than last year, and should make a better show for the Junior Cup Ties. Team;—

GUY'S.—H. H. Carter (goal); P. Cole, F. J. Turner (backs); D. G. Greenfield, A. H. Smith, P. W. L. Camps (halves); H. M. Langdale, W. O. Roberts, B. Rust, P. A. Peall (forwards).

Guy's Hospital Lawn Tennis Club.

A general meeting of the Guy's Hospital Lawn Tennis Club was held on Friday, January 20th, Dr. Washbourn in the Chair. The following officers were elected for the ensuing season. President: W. Arbuthnot Lane, Esq., M.D. Vice-President: J. W. Washbourn, Esq., M.D. Captain: P. S. Mandy. Hon. Sec.: H. K. Lacey. Committee: F. G. Cross, G. T. Willan, H. Wacher, C. N. Jupp, F. E. Fremantle, O. S. Norton, A. C. Ransford.

Guy's Hospital Chess Club.

The Second General Meeting of the above club was held on Monday, January 30th. Dr. Fawcett in the chair, and the following is a list of the officers elected and the rules carried.

President: Lauriston E. Shaw, M.D. Vice-Presidents: J. Fawcett, M.D., W. C. C. Pakes. Captain: A. D. E. Kennard. Hon. Treasurer and Secretary: E. Faulks. Committee: H. B. Dismorr, G. N. Meachen, E. H. B. Milsom, A. E. H. Pakes, R. S. Roper.

RULES OF THE GUY'S HOSPITAL CHESS CLUB.

I. This club shall be called the Guy's Hospital Chess Club.

II. All members shall be past or present members of the Guy's Hospital Clubs' Union.

III. The affairs of the club shall be conducted by a committee, consisting of the President of the society, two Vice-Presidents, the Captain of the club, five ordinary members and an Honorary Treasurer and Secretary, who may be, if necessary, elected from the five ordinary members. Each ordinary member shall represent one of the five hospital years, and each year shall be represented. Three members shall form a quorum.

IV. There shall be an entrance fee of 2/6 and an annual subscription of 2/6, payable in advance, and due on October 1st.

V. Any member whose annual subscription shall be one month in arrear, and who shall have received a notice from the Secretary requesting him to pay the amount due to the club, may, in default of compliance with such notice, be adjudged by the committee to have forfeited his membership, and shall not be re-admitted without the consent of the committee who shall, if they think fit, impose a fine of 2/6 upon re-admission.

VI. Candidates for membership shall be proposed and seconded in writing by members of the club, and shall be elected by the committee.

VII. The annual general meeting shall be held in October, when the election of officers for the following year shall take place, and any rules or bye-laws which the committee have made during the preceding year shall be sanctioned or modified. The Treasurer also shall prepare and bring before the meeting a balance sheet duly audited.

VIII. A special general meeting shall be called either by the direction of the committee or upon a requisition to the Honorary Secretary signed by ten members.

IX. Notices of all general meetings shall be posted in the colonnade of the hospital.

X. The committee shall draw up bye-laws for the regulation of the games, tournaments, etc.

XI. The captain shall be elected from the members who shall have played in the tournament held in the previous March of each year.

XII. These rules shall not be altered in any manner except at a special general meeting called for that purpose, and then not unless three-fourths of those present vote for the proposed change.

It is particularly requested that all men who wish to become members of the club will give their names up to the Secretary, or any member of the committee, as soon as possible, so that a suitable number of chess-boards and men may be provided, and other arrangements made.

Birth.

FLOYD.—On December 27th, at Moilty Llandrindod Wells, the wife of S. G. Floyd, M.D., of a daughter.

ED.—H. L. E.

Contents.

	PAGE
ABDOMINAL TUMOUR: Clinical Lecture by Dr. G. Newton Pitt	69-74
HOSPITAL NEWS	75-76
PASS LIST	76
NURSING NEWS	77
CHRISTMAS TEA AT OUT-PATIENTS: Balance Sheet	77
GUY'S NURSES' CHORAL SOCIETY	77-78
THE DENTAL SOCIETY'S DINNER	78-79
PRIZE EXAMINATIONS	79
REVIEWS	79-80
GUY'S HOSPITAL DENTAL SOCIETY	80
PASSIM	81-83
THE FUNCTIONS AND PATHOLOGY OF THE PITUITARY BODY: Paper by Mr. G. N. Meachen	83-89
APPOINTMENTS	89
SPORT: Football—Rugby: Guy's v. Kensington; Guy's v. Thomas's—Inter-Hospital Cup (2nd Round). Association Guy's 1st XI. v. Reading Amateurs; Guy's 2nd XI. v. Banstead. United Hospitals' Hare and Hounds	90-92
CHAPEL NEWS	92

Calendar of Coming Events.

Feb., 1899.

Sat. 18.—Messrs. Davies-Colley and Symonds' take-in; Drs., W. H. Brailey and E. A. Miller; Cl., W. H. M. Telling.
1.15, Clinical lecture by Dr. Taylor.
G.H.R.F.C., I., Lennox, home.
II., Lennox, away.
G.H.A.F.C., I., Old Cranleighans, home.
II., Old Cranleighans, away.
Sat. 18.—G.H.P.P.S., "Treatment of Fractures," by C. T. Hilton.
Wed. 22.—1.30, Clinical lecture by Mr. Golding-Bird.
Messrs. Lucas and Lane's take-in; Drs., R. C. Mullins and J. F. Northcott; Cl., H. L. Eason.
G.H.R.F.C., II., Merchant Taylors' School, home.
G.H.A.F.C., II., St. George's Hospital, home.
Sat. 25.—1.15, Clinical lecture by Dr. Taylor.
G.H.R.F.C., I., R.I.E.C., away.
II., St. Bartholomew's, home.
G.H.A.F.C., I., Old Brightonians, home.

March.

Wed. 1.—1.30, Clinical lecture by Mr. Golding-Bird.
Messrs. Golding-Bird and Dunn's take-in; Drs., E. Cohen and T. E. Holmes; Cl., R. H. J. Swan.
G.H.A.F.C., I., Eastbourne, away.
April Appointment List opened.
Thur. 2.—G.H.M.P.U., Address by Rev. G. R. Thornton.
Sat. 4.—1.15, Clinical lecture by Dr. Taylor.
G.H.R.F.C., I., Richmond, away.
G.H.A.F.C., I., Felstead School, away.
G.H.P.P.S., "Parasiticism," by A. H. Davies.

Guy's Hospital Gazette,

FEBRUARY 18, 1899.

Abdominal Tumour.

CLINICAL LECTURE BY DR. G. NEWTON PITT.

January 28th, 1899.

GENTLEMEN,—One of the most interesting cases in the wards at the present time, and one about which there is considerable obscurity, is a middle-aged woman, with an abdominal tumour, who has been ill for some time; it seemed to be one we might very well take to-day for discussion for the clinical lecture. I will first give you briefly the substance of Mr. Telling's report, which is a very complete one, from which I will select the more salient points.

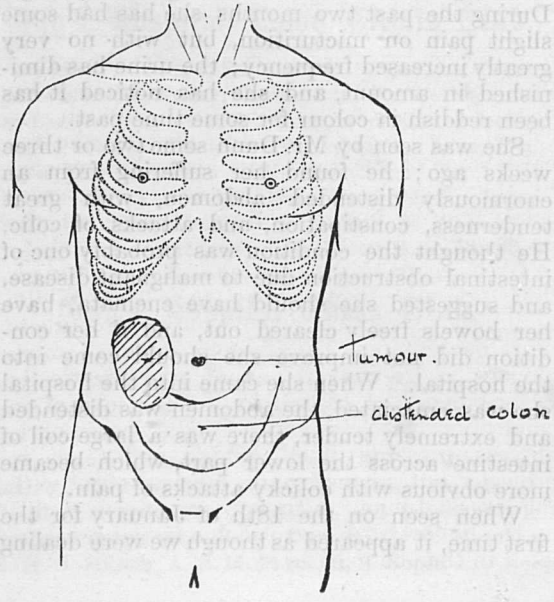
The woman is aged sixty-three, and has led an active, healthy life, having had no serious illness until two years ago. She then found she was beginning to tire readily and was losing flesh. She had some attacks of abdominal pain, not very severe, but sometimes lasting for periods of one to three weeks, and occasionally being severe enough to confine her to her bed. Previously to this she had been a stout woman. All her life she had been extremely constipated, her bowels acting once a week or fortnight with difficulty. The stools have generally been hard, scybalous masses. Two months previous to admission she found she was becoming more wasted, and was compelled to keep her bed continuously, as the pain had been very frequent. It is, she says, very agonising, and has frequently kept her awake. During the whole of her illness she has never passed any blood or mucus per rectum, nor has there been any diarrhœa or vomiting. There has been no vaginal discharge. During the past two months she has had some slight pain on micturition, but with no very greatly increased frequency; the urine has diminished in amount, and she has noticed it has been reddish in colour for some time past.

She was seen by Mr. Dunn some two or three weeks ago; he found her suffering from an enormously distended abdomen, with great tenderness, constipation, and attacks of colic. He thought the condition was probably one of intestinal obstruction due to malignant disease, and suggested she should have enemata, have her bowels freely cleared out, and if her condition did not improve she should come into the hospital. When she came into the hospital she was emaciated, the abdomen was distended and extremely tender, there was a large coil of intestine across the lower part, which became more obvious with colicky attacks of pain.

When seen on the 18th of January for the first time, it appeared as though we were dealing

with a condition of chronic intestinal obstruction. The most marked feature about this woman was in the region of the umbilicus. The abdomen was very flaccid, with a large obtruding mass, which appears to be a greatly-distended, U-shaped coil of intestine across the lower part of the abdomen. It had not the shape of a dilated stomach, but possibly was the transverse colon, which had been dragged down owing to the obstruction. The abdomen was flaccid, but owing to the very great tenderness it was not possible to make any very thorough examination. Practically that was all that was made out on the first day. The rectum was found to contain some fæces. The uterus was found free from disease with an atrophied cervix, and Douglas's pouch was distended with coils of intestine. It was not noticed that the ureters, as they passed along the side of the vagina, were thickened. The patient was ordered enemata to clear out her bowels.

Next time we saw her it became obvious that we had something more than merely intestinal obstruction to deal with, because it was found that on the right side of the abdomen, in the hypogastric region, and to the right of the umbilicus, was a large tumour which gave a somewhat impaired note on percussion, and was tender, especially when handled. The tumour was smooth, rather hard, not elastic nor fluctuating, and could be felt bimanually from back to front. The movement was very slight on respiration, and, on handling the tumour, its movement was limited in a vertical direction, but was more free from side to side. It was



ill-defined, as large perhaps as a fist, and lying back in the posterior part of the abdomen. The tumour appeared to be distinct from the liver, as you could apparently pass your hand above it, and also easily below it. Its lower end is defined and rounded, and there is a note of normal resonance between the liver and the tumour, the tumour coming close up to the margin of the ribs, but still they could be separated.

The liver was not palpable, nor could the spleen be felt. There appeared to be paroxysmal attacks of pain, and the abdomen was very tender. She also complained of a more or less constant pain in the back, but it was doubtful how severe the pain was, because the woman had lost her strength; she had been suffering pain for weeks past, and sleeping badly, and there is no doubt that she complained of a good deal of pain even when it was not apparently very severe.

On examining the urine drawn off with a catheter, it was found to contain an abundant deposit of pus and a small amount of blood. On examination the deposit was found to contain a number of pus cells, two or three granular casts, a few red blood cells, and epithelial cells, some vaginal and some renal in origin.

Our patient presents the following conditions: In the first place, great abdominal tenderness with attacks of colic; an abdominal tumour; the urine contains both blood and pus; and for some time past she has had considerable trouble with the bowels. The question we have to discuss is the association of these various conditions, and to determine whether they are entirely due to this tumour, and if so what is its nature.

I might say, to begin with, that owing to the extreme tenderness it was not possible to percuss out the abdomen and make as thorough an examination as we should otherwise have done. It appeared at first sight as though there was no doubt we were dealing with a renal tumour, as it occupied the usual position, and presented a rounded surface, but it was by no means certainly so.

The other question which we had to decide was whether the tumour might be a distended gall-bladder, and practically, owing to the great tenderness of the abdomen, we rather left the question an open one. I called in Mr. Dunn to examine the patient, and he agreed with me that the condition was one which, if left alone, would necessarily progress and shorten the patient's life, but there was just the possibility that we might be able to relieve the condition.

Without absolutely coming to any definite conclusion, the two diagnoses in our minds were, *a renal tumour* and *a distended gall-bladder*. On the whole, I was rather inclined to favour a renal tumour, while Mr. Dunn was, I think, rather in favour of its being a distended gall-bladder.

On January 24th, Mr. Dunn, on opening the abdomen, found that the liver and gall-bladder were normal, that the tumour lay behind the peritoneum, but on the peritoneum were nodules of growth. The tumour was so large and fixed, and was found to extend high up, and as there were disseminated malignant growths, it was obviously unwise to attempt removal. The abdomen, therefore, was closed. The patient has been comfortable since the operation, and seems in no way worse. A nodule of growth which was removed was found to be carcinoma on microscopical examination.

Now, I want to discuss this case, because, although we considered that the tumour was probably renal, the two most probable renal tumours associated with the presence of pus in the urine are (1) a tuberculous kidney and (2) a calculous pyonephrosis, and the question of malignant disease never entered into our minds at all. In the same way, with regard to the question as to whether it might have been a gall-bladder tumour, there is no doubt that some of these large, distended gall-bladders are associated with malignant disease of the liver. So that in discussing this case I would propose, first of all, to put before you the eight possible tumours which may occur in that region, to point out the features of malignant disease of the liver, and then to discuss what we probably have in the present case. I have put down a list here of the various tumours which occur in the right lumbar regions.

1. *Hepatic tumours.*—There is no doubt you will often have tumours which, whether malignant or due to hydatid or abscess, will be present in this region. The tumour is sometimes merely a displaced liver, *e.g.*, when you have a large accumulation of fluid in the pericardium pushing down the liver, which may reach the lumbar region. A distended gall-bladder is one of the tumours which is very difficult indeed sometimes to distinguish from a renal tumour.

2. The various *renal tumours* are—abscess, pyonephrosis, hydronephrosis, subcapsular hæmorrhage, hydatid, tuberculous and malignant disease.

3. *Local abscess*, whether traumatic or due to spinal disease.

4. *Caseous glands.*

5. A *ruptured aortic aneurysm.*—This is sometimes quite indistinguishable from a renal tumour when the rupture is retroperitoneal. You may have an enormous tumour in the midst of which the kidney is embedded. In a case some years ago we opened the abdomen and cut into the tumour, but found only a large mass of clot, which was not further disturbed, and gave rise to no immediate trouble.

6. *Accumulation of fæces.*

7. *Hydatid.*

8. *Malignant disease in glands, suprarenal or colon.*

9. *Dermoid tumour.*

10. *Ovarian tumour.*

11. *Uterine fibroid.*

You have the list before you, and I do not propose to discuss it at any length.

We have a tumour which certainly presents all the character of being renal, and which contains a carcinomatous growth. I therefore propose to bring before you some of the points which characterize a renal tumour.

First of all, with regard to the shape. A renal tumour never has any sharp edges or notches such as you may find in the spleen or on the edge of the liver. A renal tumour is invariably rounded, and, as a rule, the surface is more or less smooth. Of course, supposing you have malignant disease, that malignant disease may occupy only a portion of the tumour, and then you will have an irregula tumour. But usually you will find the tumour itself very much retains the shape of the kidney. When speaking of the shape, I might draw attention to the fact that the capsule seems to form a very considerable resistance to the spread of the growth through it. It is extremely unusual for the growth to extend through the capsule until very late in the disease. In the early stage of the disease the growth is resisted by the capsule, and consequently you very rarely indeed find secondary deposits on the peritoneum.

With regard to the position. A renal tumour first presents itself above the level of the umbilicus, excepting when you have a freely movable kidney. The tumour is much more obvious in front than behind, and practically never bulges out behind in the loin except in connection with suppuration. A perinephric abscess presents itself behind and tends to project; but in malignant disease, even with the largest tumour, although sometimes it fills up the hollow, it does not bulge it, but presents itself in the abdomen in front.

The tumour clinically very rarely crosses the middle line. This is very important as distinguishing it from a splenic tumour. A splenic tumour, as you know, is tethered by the vessels, and as it increases in size the lower margin moves towards the right until finally it lies in the right inguinal fossa, having crossed over the middle line. A renal tumour never does that; it remains on one side, and although post-mortem it may be found to have crossed the middle line, it is quite exceptional. A malignant tumour, more particularly, tends to spread upwards rather than downwards.

I have seen a malignant renal tumour on the left side extended into the axilla as high as the fourth rib. I have never seen a renal tumour extend so low that you could not get your hand between it and the pelvis. The tendency of a renal tumour, therefore, is to spread up towards the liver on the right hand, or to the axilla on the left, and not to spread down nearly so low as a splenic tumour might. Practically you may say it never extends into the pelvis, and you can in most cases, on the right side, pass your hand above the tumour, between it and the liver.

Then as to the attitude of the patient. You will find, particularly when you are dealing with suppurative and inflammatory disease, the tendency is for the sheath of the psoas to be involved early and for the patient to be lame or walk with some difficulty, leaning to one side with the thigh slightly flexed. This is more frequent with inflammatory than with malignant disease.

With regard next to the question of dulness. Renal tumours invariably have an area of dulness in front of them. Splenic and hepatic tumours never have dulness in front, unless there is also ascites, and then occasionally the liver may drop away from the abdominal wall. The tendency is for the colon to be nearer the middle line on the right side than the left, and consequently with a right renal tumour the colon is in front, or more commonly on the inner side of the tumour. On the left side you will find the colon is on the outer side or in front. When the colon is empty, if the abdomen is flaccid, you can feel the colon as a semi-solid tumour. The dulness over the tumour is not continuous with the liver dulness, and the amount of resonance, of course, varies with the amount of small intestine that happens to be in front. The position of the colon does not vary. The small intestines are constantly altering their position.

There is one more physical sign in regard to the difference on percussing over a splenic and a renal tumour. A renal tumour may take an oblique position; there is always, therefore, an area of resonance posteriorly between the upper margin of a splenic tumour and the spine. A renal tumour never has any resonance between the spine and the tumour. The difference, therefore, is this little area of resonance between the spine and the tumour.

Now as to the question of mobility. You must not lay too much stress on that. It is not at all infrequent to find a renal tumour mobile, both with respiration and also with handling. An inflammatory tumour, such as a pyonephrotic abscess, is fixed; and there is no doubt that some of the malignant tumours are fairly fixed, but so many are not that you must not lay two much stress upon the condition of mobility. Where a tumour moves at all freely on handling, you will find, as compared with a distended gall-bladder, you are able to move it up and down as freely, perhaps, or almost as much, as you can from side to side. Now, a gall-bladder tumour can be moved sideways, but allows no vertical movement on putting the patient in the knee-elbow position. A renal tumour tends always to fall back in the loin. A gall-bladder tumour tends to lie in the front of the abdomen. If you push up a renal tumour from below it tends to fall back. In the same way, in the knee-elbow position, a renal tumour is less obvious than when the patient is lying on his back, while a gall-bladder tumour becomes much more definite. The only cases in which this does not hold is when you have a freely movable kidney, and then the tumour certainly may become more obvious.

These are the physical signs which indicate a renal tumour. Now, I wish to draw attention to one or two points of difference between the physical signs of *renal tumour* and a distended gall-bladder.

With regard to a *distended gall-bladder*, the long axis is generally from a point about the extremity of the right ninth costal cartilage to a point rather below the umbilicus. It is not so broad in proportion to its length as a renal tumour. Sometimes it is very hard, and you can actually feel the stones. It may be tensely distended with fluid, and, therefore, extremely hard. It moves with respiration; it has no movement vertically; you are not able to move it up and down; and you are not able to separate it above from the liver. It is made more obvious by putting the patient into the

knee-elbow position, and it is exceptional for there to be any intestine in front of it. Those are the chief points of distinction. I have already drawn attention to the points which will distinguish a renal from a splenic tumour.

Now to pass on to a few more questions in connection with malignant tumour of the kidney. I have put up here some statistics as to the frequency of secondary deposits. Taking a series of cases, you will find secondary deposits occur either by spreading by contiguity or by means of the lymphatics or the blood-vessels. There is no doubt that, owing to the great resistance offered by the capsule, comparatively few growths spread much by contiguity. More frequently you find secondary deposits carried on by the lymphatics, the most abundant deposits being in the lungs and liver. The inferior vena cava occasionally gets blocked in cases where the growth has extended into the vessels and grown along the renal vein.

You find that malignant tumours grow at two periods of life, in quite small children, when the growth is usually a sarcoma; and after forty-five when the growth may be either a carcinoma or a sarcoma. But tumours of adult life are certainly twice as common in men as in women. Ninety per cent. of the tumours are unilateral, and they may grow for a period of even ten years or more. M. Guillet, a French writer, collected figures on the subject, and draws attention to the fact that the duration of life in malignant disease of the kidney is considerably longer than that in malignant disease of other organs. Taking a series of cases he finds that in thirty-three of them the duration of life was six months to a year, in sixteen from one to four years, in five from four to ten years, and in six over ten years. The mean duration, therefore, is practically three and a-half years.

This is a very much longer period than you find in malignant disease of other organs. The average duration of life in malignant disease of the liver is eight months, of the stomach about twelve to fifteen, of the uterus sixteen. So as the capsule of the kidney undoubtedly limits the growth of malignant disease in that organ, it is probably the explanation of this long duration of life in many cases.

As to the symptoms, they frequently consist, especially in children, at first only of a tumour. You will find a child with an abdominal tumour and with no other symptoms of discomfort, and very often for a long time that is all that can be made out. In a considerable number of cases, however, sooner or later you get pain or hæmaturia. Taking the cases of sarcoma, about 25 per cent. of the cases of children have hæmaturia before death, and about 50 per cent. of adults; whereas with carcinoma of the kidney 75 per cent. of the cases have hæmaturia. So that an adult with renal cancer will more certainly have hæmaturia than will a child with renal sarcoma. Sooner or later you get infection of other organs and progressive emaciation, wasting, and œdema.

So far as I know, you do not, in malignant disease of the kidney, get pyuria. The only case I am aware of in which pyuria was a marked symptom was a case with a large tumour now in the Middlesex Hospital Museum, in which there was calculous pyelitis with malignant disease in the kidney itself.

In our present case it is perfectly certain we are not dealing simply with malignant disease of the kidney; there is something else besides. And that is why I have chosen this case with a view to discussing what are the other conditions which may account for the pyuria.

The two most common causes of pyuria are—a tuberculous disease of the kidney and a calculous pyelitis. First of all, with regard to tuberculous disease of the kidney. The usual history in such cases is hæmaturia followed after a period by pyuria fairly considerable in amount, and, in the great majority of cases, the development of a renal tumour. Further, in such a case, in addition to those symptoms one has almost invariably met with great anæmia, pyrexia, wasting and cachexia, with evidence of disease in the lungs probably. In women there is a very notable physical sign. Where the disease has lasted long enough to form a large tumour, you almost invariably have a thickened tuberculous ureter, which you can feel on examination per vaginam. It is not present in the present case.

Then with regard to calculous pyelitis. With calculous pyelitis you usually have blood as well as pus in the urine, but you do not, as a rule, find a tumour unless you have some obstruction of the ureter. Where you have calculous pyelitis with obstruction of the ureter, the urine is invariably alkaline and foul. In our patient you would certainly have had by this time, in addition to the formation of tumour, some perinephric inflammation, and this would have set up pleurisy. So that it seems unlikely that the tumour could simply be a pyonephrotic kidney due to a calculus, considering the fact that the urine is sweet. Probably the enlargement of the kidney is due to something more than a calculus. Supposing

there is one present, and a tumour had formed under such conditions from the inflammatory products, you would have had bulging of the loin, which is absent in this case.

We have another symptom to discuss, and that is, the question of pain. The patient has great abdominal tenderness, with also paroxysmal attacks of pain. Now, the great abdominal tenderness may be simply due to the tenderness produced by the kidney. There is no doubt that with calculous pyelitis you may find very great tenderness on palpating the kidney in front, and but little tenderness on palpating the kidney behind unless there is some perinephric mischief. The pain may also be due to some local peritonitis. In favour of this view is the fact that when the abdomen was opened there were numerous adhesions found matting the intestine and kinking the intestine, and I think there is no question that the abdominal tenderness is due to local peritonitis.

The colic may be due to either gall-gladder obstruction, obstruction of the pelvis of the kidney, or intestinal obstruction. There is no evidence whatever of the gall-bladder being obstructed, and therefore we may put that out of court.

The question then is, Are these attacks of pain due to the intestine or the kidney? Now, when these attacks of pain occur, we noticed that the coils of intestine became more obvious. We have a history of chronic constipation for many years, and I think there is a very great deal of evidence in favour of the view that a great deal of the colic, if not all, is intestinal in origin. We, therefore, in discussing these various symptoms, may come to one or other of these two conclusions: First, that you have a malignant disease of the kidney; that the tumour which you feel is the kidney affected with malignant disease. In addition to that you have a calculous pyelitis. You know that in the liver it is very common to find a gall-stone associated with malignant disease. And although the association does not seem to have been frequently noted in the kidney, still I think it is quite possible a calculous pyelitis may have been the origin of the malignant disease.

Then the intestinal colic might be explained as due to matting and kinking of the intestine, and the intestinal trouble is undoubtedly increased by the passage of the colon over a tender malignant tumour.

That is one view, but there is the fact that malignant disease of the kidney very rarely spreads to the peritoneum. As a fact, this patient presented at first, both to Mr. Dunn and to myself, much more the appearance of intestinal obstruction than of renal colic; and I do not know that we can altogether exclude the view that we may be dealing with a small growth in the colon which we have not been able either to feel or see, with secondary nodules of growth in the peritoneum. The tumour may be a mass of growth in the glands, or possibly infiltrating the kidney as well, but if it does so it has started first in the glands. The pus in the urine which apparently has been noticed for two months only, may be due to some portion of this growth pressing on the ureter and interfering with the passage of the urine, and allowing a pyelitis to take place.

It is very difficult, in fact quite impossible, to separate definitely and be quite certain as to which of these two causes is present. It is very difficult indeed where you have a growth close to the kidney, and surrounding it, and running into it, to differentiate it from a growth which is limited to the kidney entirely. But, at the same time, the long-continued history of constipation, and the markedly distended condition of the intestine in the lower part of the abdomen, are two points that ought not to be lost sight of. We certainly have at least two lesions; at present the patient is fairly comfortable, and we shall not adopt any more active treatment. It is quite clear that it would be impossible to remove the tumour, and even if the trouble were primarily intestinal, the presence also of this tumour would prevent our doing anything there at present in the way of relieving her.

The treatment, therefore, consists simply in giving her sufficient morphia to alleviate her pain and to get the bowels fairly regular. But where for twenty years the patient has been in the habit of having the bowels opened once a week only, the colon becomes enormously distended, the walls are very weak and possess very little contractile power.

Papers by Guy's Men.

Notes on a Case of Cyst of the Great Omentum removed by Operation. By James Braithwaite, M.D. Lond.—*Lancet*, 3rd December.

A Case of Influenza, illustrating the importance of a bacteriological examination. By J. W. Washbourn, M.D., F.R.C.P. Lond.—*Clinical Journal*, December 7th, 1898.

Four Cases of Insanity after Injury to the Head, with Observations relative thereto.—*Lancet*, 10th December.

Fractures and their Treatment. By W. Arbuthnot Lane, M.S. Lond.—*Clinical Journal*, 14th December.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Pye-Smith.

Philip
21. Typhoid.
22. Right pleuritic effusion. Phthisis, left apex.
24. Phthisis, right and left apices.
25. Pleuritic effusion. Pneumonia.
26. Lardaceous disease.
28. Bright's disease.
29. Typhoid.
30. Chorea. Mitral regurgitation.
31. Tabes.
34. Chronic Bright's disease. Uræmia.
35. Appendicitis.
36. Aortic regurgitation. Hypertrophied and dilated left ventricle.
37. Dilated stomach. Phthisis, left apex.
38. Typhoid.
39. Left pleurisy.
40. Acute rheumatism.

Mary
25. Chronic interstitial nephritis.
27. Gastric ulcer. Apical systolic murmur.
28. Mitral regurgitation. Albuminuria.
29. Mitral stenosis and regurgitation.
30. Chorea. Systolic apical bruit.
31. Trigeminal neuralgia.
32. Morbus cordis.
33. Typhoid.

Cot.
Intussusception. Operation 8th February, 1899.

35. Ascites. Anasarca. ? Cirrhosis.
36. Phthisis, left apex.
37. Tubal nephritis.

Cases under Dr. Taylor.

Stephen
1. Chorea. Mitral regurgitation.
6. Pleurisy. ? Phthisis.
7. Typhoid. Relapse.
9. Renal colic. Operation. Stricture of ureter.
11. Rheumatism. Aortic and mitral regurgitation.
13. Cerebral hæmorrhage.
16. Arterio-sclerosis. ? Mitral incompetence.

Mary
38. Hæmoptysis. Bronchiectasis. ? Basal Phthisis.
44. Vertigo. Functional paresis of legs.
45. Typhoid. Relapse.
50. Chronic Bronchitis. Cirrhosis.
56. Broncho-pneumonia.

Cases under Dr. Washbourn.

Philip
1. Mixed nephritis.
3. Retention of urine.
7. Typhoid.
9. Cirrhosis.
12. Pleurisy. ? Growth.
13. Tubal nephritis.
17. Plumbism. ? Growth. Nephritis and cystitis.
18. Bronchitis and bronchiectasis.

Mary
13. Hæmoptysis.
16. Pulmonary regurgitation following infective endocarditis.
17. Chronic uræmia. Failing heart.
18. Hemiplegia.
19. Acute rheumatism.
20. Carcinoma of liver and pylorus.
22. Gastralgia.
24. Mitral stenosis and regurgitation. Tricuspid regurgitation.

"Clinical."

John
2. Enterica.
4. Enterica.
6. Oxalic acid poisoning.
7. Syphilitic pachy-meningitis.
8. Appendicular abscess.
11. Enterica.
12. Hydronephrosis.
13. Appendicular abscess.
15. Empyema.

Miriam
18. Enterica.
19. Nephritis.
20. Mitral stenosis and incompetence. Pleuritic effusion. ? Lateral sinus thrombosis.
23. Aneurysm of aorta.
24. Congenital heart disease.
27. ? Hodgkin's disease.
29. Castor-oil bean poisoning.
30. Castor-oil bean poisoning.
31. Mitral stenosis and incompetence.
32. *Broncho-pneumonia.*
33. Broncho-pneumonia.
34. Broncho-pneumonia.
35. Diphtheria. Tracheotomy.
36. Diphtheria. Tracheotomy.

In the Surgical Wards.

Cases under Mr. Howse.

Naaman
1. Thecal whitlow.
4. Otorrhœa.
12. ? Tuberculous knee. ? Sarcoma of lower end of femur.

Charity 6. Recurrent carcinoma mammæ affecting other breast. Excised.
12. ? Bruised hip. ? Fractured neck of femur.
17. Cervical caries.
18. Bronchocele.
19. Moveable kidney.
Cot D. Mastoid sinus.
Astley Cooper 1. ? Middle meningeal hæmorrhage. Death.
25. Stabs in abdomen.
Cot. Fractured femur.

Cases under Mr. Davies-Colley.

Luke 9. Median and ulnar paralysis from shot wound. Resection.
12. Undescended testis. Castration.
Lydia 23. Spinal caries, with spastic paraplegia.
Cornelius 3. Fractured ribs.

Cases under Mr. Lucas.

Job 1. Epithelioma of leg. General eczema.
5. Epitheliomatous glands, secondary to lip, adherent to mandible.
9. Tuberculous cystitis.
Charity 1, 2. Old hip disease.
21. Lateral curvature of spine.

Cases under Mr. Golding-Bird.

Astley Cooper 8. Crushed foot. Amputation through leg.
17. Fractured jaw.
19. Fractured femur.
Cornelius 16. Bullet in hand.
18. Fractured patella.
Martha 2. Carcinoma mammæ.
7. Strangulated umbilical hernia.
16. Sinus after Kraske's excision of rectum.
Lazarus 13. Tuberculous sartorial bursitis and cyst of superior tibio-fibular joint.
19. ? Deltoid neuralgia. ? Osteo-arthritis of shoulder.
20. Hallux erectus.
21. Tuberculous elbow.

Cases under Mr. Jacobson.

Victoria 4. Ovarian cyst. Ovariotomy.
6. Ankylosed knee after puerperal arthritis.

Cases under Mr. Symonds.

Martha 13. Dentigerous cyst. ? Periosteal abscess of upper jaw.
15. Nasal polypi.

Cases under Mr. Lane.

Job 12. Empyema.
Lydia 16. Perforated gastric ulcer. Peritonitis. Laparotomy.
Samaritan 8. Tumour of buttock. ? Teratoma.

Cases under Mr. Dunn.

Lazarus 3. Acute appendicitis. Abscess incised.
Martha 12. Branchial sinus in neck. Excised.
Cot. Nævus on nose. Excised.

Pass List.

University of London, January, 1899.

Intermediate Examination in Medicine.

Entire Examination (Second Division).—G. T. Collins, H. B. Foster, H. C. Keates.

Excluding Physiology (First Division).—M. A. Collins. (Second Division).—W. J. Davies, H. A. Ehrlich, G. Evans, A. C. H. Gray, C. B. Penny, E. F. Reeve, W. M. Robson, D. H. Trail.

Physiology only (First Division).—S. J. Ormond, A. Pearson, A. C. Ransford. (Second Division).—D. Forsyth, E. T. Jensen, O. Marriott, T. A. Matthews, M. J. Rees, D. W. Smith.

Preliminary Scientific Examination.

Entire Examination (First Division).—D. Isaacs.

Biology only.—P. A. S. Dyson, P. A. Peall, G. H. Rees.

Final Conjoint Examination, January, 1899.

Medicine, Surgery and Midwifery.—*F. W. Brook, *J. T. Dunston, *J. Matthews.

Medicine and Surgery.—*V. J. Crawford, *T. H. W. Landon, *H. S. Turner.

Surgery and Midwifery.—V. T. C. Bent, J. H. Roberts.

Medicine only.—*H. M. Berncastle, *A. H. Carter *A. E. Clarke, *P. J. Curtis, E. A. Evans, R. Michell, A. A. Miller, *R. J. Pritchard, S. A. Ruzzak, H. C. Sturdy, *F. D. Turner.

Surgery only.—W. L. Baker, H. W. Fox, J. Howells, *J. H. Jones, *A. H. B. Kirkman, C. D. Outred, *F. L. Rae, *E. W. S. Rowland, A. R. Thomas, C. F. Watson.

Midwifery only.—C. H. Brangwin, H. N. Clarke, H. S. Crapper, H. R. H. Denny, H. Durbridge, *A. Evans, *Evan Evans, C. W. Gibson, W. W. Harrison, J. T. M. McDougall, A. R. McLachlan, G. N. Meachen, *W. T. Milton, *F. J. Nicholls, E. W. H. Shenton, C. B. Thomson, *F. E. Walker.

* Denotes completion of Examination.

Second Conjoint Examination.

H. W. Brown, M. Coplans, J. F. Douse, C. E. Gaitskell, A. W. Gater, F. D. S. Jackson, A. C. Nash, L. G. Nash, A. W. Soper.

First Conjoint Examination.

Chemistry and Physics.—G. L. Buckeridge, G. F. Hardy, E. N. Jupp, F. B. Lowe, D. H. Richards, H. L. Shelton.

Biology.—S. C. Bowle, I. S. Sheffield.

Practical Pharmacy.—S. C. H. Bent, W. R. Cazenove, J. T. De Coteau, P. L. Hickes, R. Jiménez, R. J. Pritchard, W. O. Roberts, G. Shorland, E. J. Tongue.

Materia Medica and Pharmacy.—G. M. Brown, L. C. Martin.

Nursing News.

On February 13th, Nurse Searle left the hospital to join the Private Nurses' Institution after nearly four years' work here, and three years at the Hospital for Sick Children at Shadwell. Probationer Arnold has been appointed Head Nurse in John ward in her place. On February 14th, Nurse L. Taylor left the hospital. She had served here for three and a half years, and was called away on account of the failing health of her father. Nurse J. Gray has been transferred from Patience to Philip, and Probationer Pearce has been made Head Nurse in Patience.

Guy's Hospital Nurses' Recreation Society.

A Meeting of the members of the Cycling and Tennis Clubs, and of the Choral Society, will be held at the Matron's home on Wednesday, February 22nd, at 8 p.m. The attendance of all members of these Clubs is particularly requested, and other nurses interested in the movement are also invited to be present.

Business.

1. To consider the draft rules drawn up by the Provisional Council.
2. To enrol members.
3. To elect a Council for the remaining portion of the year.

MAY H. SHAW, Hon. Sec., pro tem.

Christmas Tea at Out-Patients.

BALANCE SHEET.

Receipts.	£	s.	d.
Collecting Cards (Nurses)	78	16	1
From the Staff	12	12	0
Students and Friends	20	16	6
	£112	4	7

Expenditure.	£	s.	d.
Caterer	27	12	11
Children's Toys, Entertainment, etc. ...	34	19	7
Decorations	16	18	8
General Expenses	9	9	0
	89	0	2
Balance	23	4	5
	£112	4	7

Examined and found correct,
VICTOR E. COLLINS,
Jan. 30, 1899. CORTIS R. HODGSON.

Guy's Nurses' Choral Society.

On Monday and Tuesday this week the Nurses' Choral Society and the Students' Glee Club gave their third annual concert. Of the two evenings, Tuesday was the better, but both nurses and men are to be heartily congratulated on two excellent entertainments, and it is gratifying to note a marked improvement upon last year's efforts.

Miss B. Starling commenced the programme with a Phantasie-Stück of Schumann, which she played with excellent technique. The Cantata chosen for this year's performance was "May-Day," by Sir George Macfarren, a work not particularly inspired or inspiriting; but we are concerned with criticism of performers rather than of compositions, and for the former we have nothing but praise for their interpretation. The best part of the work was Part III., "The Queen's Greeting," admirably sung by Nurse Daniell, and encored each evening. The Finale, "The Revels," rather belied its title, as it was evidently too well rehearsed and lacked spirit, and we noticed a marked tendency to drag on the conductor's beat. Throughout the Cantata the altos and basses were better than the opposite side, singing with greater smoothness, confidence and attack, the majority of the sopranos being timid in the high passages. Mr. Starling was a tower of strength among the tenors, but one voice cannot simulate a chorus, and more tenors are obviously needed to make the parts balance.

The second part of the programme was more attractive than the first, the part-singing being very good, particularly in "Sing a Roundelay," and "The Cruishkeen Lawn," the latter being the most artistic performance of the evening. On Monday, Mr. Starling sang "A Dream," by Rubinstein, as well as he has ever sung, and fully deserved an encore. His efforts were better appreciated, however, on the following evening, when he sang Meyer Helmund's old-fashioned Serenade, followed by "The Sea hath its Pearls," by M. V. White. Mr. Cazenove sang "O lucky Jim," from "The Belle of New York"—a very slight composition, depending for its success entirely upon its rendering, and as an encore gave the ever-popular "Sing me a Drawing Room Song, Darling."

Sister Christine sang "Vorrei Morire," by Tosti, a song of far greater artistic worth than the ordinary ballad usually associated with his name. Sister Christine has one sterling quality, a necessity to any great singer, the power of enforcing attention, both by her personality and by a certain dramatic method of singing. She was encored both evenings, but on neither occasion was her second song given in quite her best style, we think she was overworked. Mr. Handson was most enthusiastically received on both nights in "When Thine Eyes," by M. V. White, and Mr. Parrott sang "The Norseman's Song," by Francis Allitsen, exceedingly well, and with much power, albeit a trifle slow. As an encore he successfully courted humour in the song from "The Sorcerer," "Time was when Love and I were well acquainted."

Miss Spalding played as a violin solo Vieuxtemp's "Reverie," and gained a well-deserved encore, her intonation being exceptionally accurate, and her interpretation being marked by admirable feeling.

The quartette, "Good-night, Beloved," by Nurse Daniell, Nurse Custance, Messrs. Starling and Parrott, was one of the best items in the second part, and lost nothing at the hands of the performers. As a composition we have no use for "Good-night," by Garrett, but the solo parts were well sung by Nurses Cheetham and Custance.

After all criticism, and to sum up, we had two very pleasant evenings, and the Choral Society and the Glee Club are to be heartily congratulated.

To Mr. Taylor great praise is due for his most careful training of the chorus, and his share in the success of the evening was a very large one.

The Dental Society's Dinner.

THE Fourth Annual Dinner of the Guy's Hospital Dental Society was held on Saturday evening last, February 11th. The meeting was an unqualified success, and the attendance of members was the largest since the foundation of the Society four years ago. Mr. Montague Hopson was in the chair, supported by many members of the Dental and Hospital Staff, including Mr. Maggs, Mr. Pare, Mr. Davies-Colley, Dr. Washbourn, Mr. Groves, Dr. Bryant, Mr. Baker and others

At the conclusion of the dinner, the toasts of the Queen and Royal Family having been drunk, the President proposed the health of "Guy's Hospital, the Medical and Dental Schools." He remarked that the difficulties of the L.D.S. examination at the Hall by the river was as nothing to the difficulty of making an after-dinner speech, and he prayed the indulgence of the audience, as in an examination one could lay the blame of failure upon another, to wit, the examiner, whereas, in an after-dinner speech, one only had oneself to blame. He would give them the health of Thomas Guy (cheers). Carlyle had said that popular opinion was the biggest lie on earth, and he quite agreed with him, as popular opinion had always marked out Thomas Guy as a selfish, stingy, somewhat immoral speculator. But, thanks to Wilks and Bettany, that fable was confuted, and Thomas Guy stood to-day in the proud position of a pure philanthropist. He would also give the toast of the two Schools, two institutions with a common interest (cheers). He warmly eulogized the good management of both Schools, and pointed out that the success of the Re-Endowment Fund was but a public recognition of these worthy efforts.

The chairman then read a telegram which he had just received from the Edinburgh Students' Dental Society, expressing their warmest sympathies, and this announcement was received with rapturous applause.

He regretted the unforeseen absence of Dr. Taylor, and would couple with the toast the name of Mr. Groves (cheers). In conclusion, he could only remind his hearers that as long as they remained true to the traditions of Guy's Hospital the success of the Dental School was assured.

Mr. Groves, in reply, commenced his speech by a vigorous dose of self-depreciation which was entirely belied by his subsequent speech. He pointed out that since the advent of Mr. Bonsor the barrier between the Staff and School had been largely broken down. He could mention, as a tribute to the Dental School, no more encouraging fact than that the entry of the Guy's Hospital Dental School last year was larger than the combined entry of the two other London Schools.

Mr. Davies-Colley rose to propose the health of the Dental Society. He remarked that the Dental Society was not as young as it appeared, and was in reality only a healthy graft upon the old Guy's Hospital Physical Society, one of the oldest medical societies in London. In some respects it was an improvement upon the parent stock, notably in the matter of the annual dinner. (Laughter.)

Mr. Maggs having replied, Dr. Silk proposed the health of the Visitors, coupled with the name of Mr. Bland-Sutton.

Mr. Bland-Sutton said that if he were one of the Dental Society he should much object to the application of the word "graft" by Mr. Davies-Colley as applied to the Society. Mr. Davies-Colley was interested in agriculture, and naturally drew his metaphors from his favourite pursuit, whereas he (Mr. Bland-Sutton) was an enthusiast in the matter of breeding animals, and always insisted on purity of birth. Now, he should say that the Guy's Hospital Dental School was the child of aged parents, in the same sense as Isaac was the son of Abraham and Sarah. If the dental students at Guy's Hospital only prospered and multiplied as the chosen children of Israel, he could wish them no better future.

Dr. Washbourn then rose to propose what he said was the most important speech of the evening—the toast of the chairman, Mr. Montague Hopson, the first student in the Guy's Hospital Dental School, and its most popular member.

The Chairman responded, and after the health of the secretary, Mr. Hayes Palmer, had been drunk amid much enthusiasm, the proceedings terminated with "Auld Lang Syne."

During the intervals between the toasts the following musical items were given, the most successful efforts being songs by Mr. E. C. Bartlett, "The Father of the School," and topical songs by Mr. W. H. Pilcher. Piano duet, Dance from "Henry VIII.," E. German, Messrs. Rowlett and Sydney Jones. Song, "When all was young" (Faust), Gounod, Mr. E. C. Bartlett. 'Cello solos, "Schlümmerlied and Arlequin," Mr. W. Rowlett. Song, "On the Banks of the Thames," Mr. A. Stradling. Song, Topical, Mr. W. H. Pilcher. Song, "The Merry Monk," Mr. H. T. Campkin. Banjo solo, Mr. A. Stradling. Song, "You do it with a motion of the hand," Mr. Sydney

Jones. Mr. T. Godfrey, who was billed to appear, was prevented from appearing by illness.

Prize Examinations.

Competition for the undermentioned Prizes will take place on the following dates:—

The Arthur Durham Prizes for Dissection.—Monday, March 6, 10 a.m.

Junior Prizes for General Proficiency.—Wednesday, March 22, 10—1, Elementary Anatomy; 10—1, Anatomy; 2—5, Physiology. Monday, July 24, 10—1, Histology.

Michael Harris Prize in Anatomy.—Wednesday, March 22, 10—1. The date of the Practical Examination will be announced later.

Wooldridge Memorial Prize in Physiology.—Wednesday, March 22, 2—5. The date of the Practical Examination will be announced later.

Senior Prizes for General Proficiency.—Wednesday, March 22, 10—1, Clinical Medicine; 2—5, Medicine. Thursday, March 23, 10—1, Clinical Surgery; 2—5, Surgery. Friday, March 24, 10—1, Medical Jurisprudence; 2—5, Public Health. Monday, July 24, 10—1, Pathology; 2—5, Midwifery and Diseases of Women. Tuesday, July 25, 10—1, Pharmacology and Therapeutics; 2—5, Mental Diseases.

Bredin Prize for Clinical Study.—Monday, May 1. Last day for presenting Reports to the Dean in the Medical School Office.

Beaney Prize in Pathology.—Monday, July 24, 10—1. The date of the Practical Examination will be announced later.

Treasurer's Medals.—Monday, June 5, 10—1, Surgery; 2—5, Medicine. Tuesday, June 6, 10—1, Commentary on a Case in Medicine; 2—5, Commentary on a Case in Surgery. Wednesday, June 7, 10—1, Clinical Examination in Medicine; Thursday, June 8, 10—1, Clinical Examination in Surgery. Operations to be announced later.

Golding-Bird Gold Medal and Scholarship.—Thursday, March 23, 10—1, Paper; 2—5, Practical. Friday, March 24, 10—1, Paper; 2—5, Practical. Saturday, March 25, 10—1, Practical.

Dental Prizes (First Year's Students).—Tuesday, March 14, 2—5, Anatomy. Wednesday, March 15, 10—12, Physiology; 2—5, Dental Anatomy. Friday, March 17, 2—5, Dental Surgery. Monday, June 5, 9 a.m., Conservation Room Examination. Thursday, June 8, 2 p.m., Clinical Examination. Saturday, June 10, 9 a.m., Laboratory Examination. (1900 Prize.) Tuesday, December 12, 2—4, Metallurgy. (Second Year's Students.) Tuesday, March 14, 2—5, Anatomy. Wednesday, March 15, 10—12, Physiology; 2—5, Dental Anatomy. Thursday, March 16, 2—4, Surgery. Friday, March 17, 2—5, Dental Surgery. Monday, June 5, 9 a.m., Conservation Room Examination; 2 p.m., Clinical Examination. Saturday, June 10, 9 a.m., Laboratory Examination. Friday, June 16, 9 a.m., Special Examination for Prize for Practical Dentistry. Friday, July 21, 2—5, Dental Microscopy. (1900 Prize.) Tuesday, July 18, 2—5, Dental Mechanics (Paper). Thursday, July 20, 2—5, Operative Dental Surgery (Paper).

No Candidate will be allowed to compete for any Prize unless he has given notice in writing to the Dean at least *fourteen clear days* before the commencement of the Examination.

The Examinations for the Open Scholarships in Arts and Science will be held on September 26th, 27th and 28th.

Reviews.

The Open-Air Cure of Consumption.

Sanatoria for Consumptives. By F. R. Walters, M.D., F.R.C.P., Physician to the North London Hospital for Consumption and Diseases of the Chest. (London: Swan Sonnenschein & Co., pp. 374, 41 illustrations.) 10s. 6d. net.

The Open-Air Cure of Consumption: a Personal Experience. By James Arthur Gibson. (Nineteenth Century, January, 1899.)

At the present moment, when tuberculosis in animals and man is the popular hygienic question of the day, and, under the presidency of H.R.H. the Prince of Wales, a Commission is sitting to discuss the problem of combating its spread, a book like Dr. Walter's is most opportune.

The majority of practitioners, unless they have travelled and personally inspected many of the English and Foreign Sanatoria, have but the vaguest idea of the routine or method in practice at each individual institution, or in what way one locality may be preferable to another in the various cases of phthisis that come under their care. Among students the ignorance of the hygienic treatment of phthisis outside a hospital is even greater. A case of phthisis is in the hospital, and the physician's simple question, "If you had the care of this patient in private practice, how would you treat him?" is invariably met with the mechanical reply, "Send him to Davos", regardless of whether the patient has a large cavity and is in the last stages of the disease and cachectic in the extreme, or whether the only signs may be a single attack of hæmoptysis and a few râles at one apex. A detailed system of hygienic treatment is unknown to them, and the single word "Davos" sums up the whole question.

As a matter of fact, in very many cases, Davos is, of all places, most unsuitable for patients who are at all ill, as, if sent there, they go with friends, and on arrival they are plunged into such a continuous whirl of excitement that at the end of three months they are in a worse state of health than if they had remained quietly at home.

For some years, especially in Germany, now also in England and the United States, the tide of medical opinion has been running in the direction of regular hygienic, non-medicinal treatment, under direct medical supervision at sanatoria, buildings, if possible, in high situations and clear air and remote from towns or even villages. Of these sanatoria the first to become famous was Nordrach, in the Black Forest, which still holds pre-eminence in many respects. Here patients are kept under strict medical supervision, and live as much as possible out of doors. People who at home would be kept carefully in the house and in warm rooms to prevent them catching a chill, are at Nordrach sent out for walks all day long in all weathers, getting drenched to the skin; they live in a climate quite as cold and damp as England, with windows always open, and are gradually inured to any climatic condition. During the whole of their stay they are methodically stuffed with food, in quantities so large that they would marvel at them at home and turn away in sheer disgust. They gradually put on weight, and the physical signs in their chest diminish proportionately to the increase in their general nutrition, and they leave Nordrach healthy, well-nourished individuals, with no signs of active phthisis whatever. This is practically an outline of successful sanatorium treatment anywhere in an early case of phthisis.

It is a popular idea that climate has a great influence upon consumption. This idea Dr. Walters labours successfully to refute, taking as his authority the well known statement of Dr. Leon Petit, "We are nowadays convinced that there is no climate, however favoured, which by itself can cure consumptives." He points out that the essentials are rather, regular exercise and thorough, if not excessive, feeding.

The book is well arranged and very thorough, and, as far as we can see, the subject is treated quite impartially, and is in no way an advertisement of any particular sanatorium or sanatoria. The first part consists of a general review of the subject of the open-air treatment of consumption, and the following section consists of a series of very methodical and acute descriptions of each particular well-known institution, with accounts of their climatic situation, management and mode of treatment. Altogether, a most valuable and suggestive book for any medical man who may have the present care of phthisical patients.

In the *Nineteenth Century* for January there is also an interesting article by Mr. James Arthur Gibson, presumably not a medical man, being an account of his experience at Nordrach, under the care of the well-known Dr. Walther. At the age of 28, completely broken down in health, suffering from acute phthisis, and told that his case was desperate, as a forlorn hope Mr. Gibson went to Nordrach on the recommendation of a friend. He arrived there in October, 1895, weighing 9st 12lbs, and left in January, 1896, three and a half months later, weighing 12st 8lbs, having put on a stone a month, and quite cured of his phthisis, at least up to the present time. Small wonder, then, that he has nothing but praise for Nordrach and its régime, and sees no reason why anyone should die of phthisis!

Discounting his enthusiasm, however, he has given a vivid and instructive account of the manner of living at Nordrach, a system consisting of three out-standing features—over-feeding, regulation of the amount of exertion and rest, and pure air. According to his account, the average time required to effect a cure is five to six months, and from the figures given in Dr. Walter's book we find that of all the patients going to Nordrach, in all stages of the disease, 30 per cent. are cured and 95 per cent. improved. But both the book and the article should be read in their entirety and read together.

Guy's Hospital Dental Society.

THE usual monthly meeting of the above Society was held on Tuesday, January the 10th, at 5 p.m. The President, Mr. Hopson, in the chair. The minutes of the previous meeting were read and confirmed, after which the following casual communications were brought forward:—

Mr. DOWSETT showed models of two cases of syphilitic perforation of palate; also models of saddle-shaped and contracted arch in a man markedly mentally defective.

Mr. MAURICE showed an upper model with permanent canines which had erupted, having displaced, by absorption, the permanent centrals.

Mr. WARTSKI for Mr. Rose showed an upper model of U-shaped arch with two supernumeraries *in situ*.

The President then called on Dr. Pare for his paper on "Extinct Teeth," which took the form of a demonstration by the aid of the oxy-hydrogen lantern, by which about fifty very interesting slides were shown, on the teeth of extinct fish, reptiles, birds, ant-eaters, ungulates, and marsupials. The teeth were contrasted with those of existing forms, and some of the slides attempted to show the forms of those long ago extinct creatures, such as the mammoth, mastodon, macrochænia, sabre-toothed tiger, labirynthrodon, and some extinct birds.

A short discussion then followed, after which Mr. Plumley passed a vote of thanks to Dr. Pare for his excellent demonstration, thus terminating the meeting.

P. H. HAYES PALMER, Hon. Sec.

Papers by Guy's Men.

The Treatment of Lateral Curvature of the Spine by Physical Exercises and Position. By George Steele Perkins, M.D. *Medical Press*, November 23rd.

An Address on the Present Knowledge of Outbreaks due to Meat Poisoning. By Herbert E. Durham, M.A., M.B., F.R.C.S. *British Medical Journal*, 17th Dec., 1898.

Infective Sarcomata in Dogs. By G. Bellingham Smith, M.B., B.S., and J. W. Washbourn, M.D., F.R.C.P. *Ibid.*

Two Cases of Cæsarean Section. By James Braithwaite, M.D. Lond., M.R.C.S. Eng. *Lancet*, 31st December, 1898.

Varieties and Virulence of the Pneumococcus. By J. W. Eyre, M.S., M.D. Durham, and J. W. Washbourn, M.D., F.R.C.P., Lond.

Passim.

We regret to announce the death of Mr. Charles Bader, consulting ophthalmic surgeon to the hospital, which occurred at his country house at Stoke Ferry, Norfolk, on the 13th inst. He came over to Guy's from Germany in November, 1861, and was appointed assistant ophthalmic surgeon to Mr. Alfred Poland. He became ophthalmic surgeon in 1873, and consultant in 1882. He carried on a large practice in Finsbury Circus throughout his professional career. We hope in the next Gazette to publish some fuller account of his life and his valuable contributions to modern ophthalmic surgery.

Everything comes to him who waits: and sometimes when it does come it comes with a vengeance. After waiting ten years to beat St. Thomas's, we did it last year by the respectable score of 18 points to 4, and this year we were victorious by the mere trifle of 26 points to nil. Verily the star of our Rugby football team is in the ascendant, and if only the luck holds there is a good chance of keeping last year's winnings.

Last Tuesday's game was a good one to watch, but lacked excitement in the latter half, the result of the game being a foregone conclusion, even though our team was only playing seven forwards. The striking feature of the afternoon was the masterly play of O'Brien at three-quarters. Here we have a man of real sterling merit, a man who plays a cool scientific game and never loses his head; if he keeps up to his present form he will be one of our best players of recent years.

The chief credit of the afternoon's result is, however, due to R. C. Mullins, who has been the life and soul of the forwards for the last two years, and whose splendid example of skill and keenness has brought the pack up to their present high standard of play.

The match last Thursday between Mary's and Bart.'s resulted in a somewhat unexpected victory for the first-named, but undoubtedly the better team won. There was no scoring during the first half, though play was practically all the while in the Bart.'s half of the ground. About half way through the second half Cowey effected a wonderfully smart run, and scored in a favourable position, and later on Le Bas, the left wing three-quarters got in by the touch line. So Mary's won by eight points to nil. They have a very useful even pack of forwards, and Luxmoore, Graham, and Pooley were exceptionally good. Our men will have to pack exceptionally quickly and break up smartly to better them. They are very good, too, at the line out and in the loose. Outside, Mary's are hardly as good, but Crozier, the right half, and the two centre three-quarters will want a lot of watching. It will be absolutely fatal to let Cowey through even once, as there are few players better than the London Scotsman at seizing any opening. As all their backs are small—very small in fact—the tackling will have to be invariably quite low. The Mary's full back kicked well but did not often find touch. He made up for it, however, a good deal by very smart following up. Altogether, our men will have to go hard all the way, and to our mind they will have no better opportunities than in the first quarter of an hour.

On Saturday, February 25th, the Inter-hospital Cross Country Cup will be decided. The course is a long one, twice round the five mile run. In contrast to the last two years, there will be some competition, as four hospitals, Guy's, Thomas's, Bart.'s, and Mary's, have all entered teams. Guy's will be represented by the following men, who, we hope, will uphold the honour of the hospital as in former years. F. E. Fremantle (Captain), R. S. Roper (Secretary), F. J. Robinson, R. M. Barron, and R. E. Brayne, S. J. Ormond (reserve). Trains, 2.32 and 3.3 to Chingford. Fare, 1/- return.

The Residents' Dance was held on Thursday, February 9th, and proved a great success. It was more crowded than last year, but not too full for comfort, but unfortunately, owing to unavoidable circumstances, many members of the Staff who have been present in former years were prevented from coming. In the absence of Mrs. Cosmo Bonsor, Mrs. Hambro kindly consented to act as hostess, and her attractive presence contributed in no small degree to the success of the evening.

The difference between dancing and singing is that you can sing with the Nurses. Consequently the flower of Guy's manhood stood up on Monday and Tuesday last and helped the Nurses' Choral Society to give two pleasant evenings' entertainment. The principal credit is due to three people, Mrs. Shaw, who is such a devoted worker in the Choral Society, Sister Christine, and Mr. H. J. Starling, the respective

Honorary Secretaries. We hear that upwards of £38 was the result of the concert, and this sum is to be handed over to the Nurses' Choral Society Piano Fund.

We also hear that the wife of one of the members of the Staff, whose name we cannot divulge, remarked that she couldn't help admiring Mr. Starling's singing, it was so fashionable.

During the last fortnight the hospital has lost by what one man has gained. Miss White, who has been L.P. here for the last year, has just left the hospital, and her engagement to Mr. J. M. Fortescue-Brickdale is announced. We wish them both the best of luck. With Mr. Brickdale's conversion to the all-absorbing pursuit of the analysis of the affections, comes the inevitable death of the *Guyoscope*, which he has so ably edited for the past twelve months. Whether there will be a final number of the *Guyoscope* we do not know, we sincerely hope there may be; certainly its demise will be a great loss to the hospital, as in the two short years of its existence it achieved greater fame than any other hospital paper, and was of no small internal benefit here by reason of its light-hearted criticism of both great and small.

We also regret to notice the departure of Nurse Searle, who has been Staff Nurse in John ward for the last two and a half years. A very capable and unassuming nurse, she will be greatly missed in the ward, and the Institution is to be congratulated on the acquisition of her services.

As a rule we do our best to avoid complaints in these columns, but quite recently two most legitimate grievances have been brought to our notice, both, we regret to say, concerning the behaviour of the men. The first thing we have to complain of is the growing habit of smoking in the Front Surgery. Formerly, smoking was strictly confined to after dinner in the evening, now men feel aggrieved if they are requested by the A.H.S. not to smoke while dressing the patients at the early hours of eleven or twelve in the morning. We would emphatically protest against this new custom as being in the highest degree unprofessional and slack, and little calculated to improve public opinion of Guy's men and their work.

Our second grievance is, unfortunately, an old one, to wit, against the practice of leaving lectures directly the janitor has taken names. The continued scuffle of ill-mannered folk who have taken to leaving clinical lectures on Saturdays is a constant source of annoyance to the rest of the audience, besides being a direct insult to the lecturer. Why cannot men be honest and stop away altogether if they have not the strength of mind to sit out one hour's lecture after having, possibly with some difficulty, made up their wandering minds to come?

The Dental Society dinner on Saturday last at the Criterion was a grand success, the gathering being very large and the speeches far above the average. We cannot refrain from paying a sincere tribute to the Secretary of the Dental Society, Mr. P. H. Hayes Palmer, who by his unfailing courtesy and zeal contributed so largely to the success of the evening. His reception at the close of the dinner was well deserved. The most notable visitor at the dinner was Mr. Bland Sutton, who made a most humorous reply for the visitors.

At the next meeting of the Guy's Hospital Missionary Society, on Tuesday next, a presentation will be made to Mr. Robert Howard, M.B., B.Ch., who is shortly leaving the hospital to take up medical missionary work in Central Africa. The speaker will be the Rev. P. R. Chambers, of the Universities' Mission to Central Africa. C. J. Symonds, Esq., will take the chair. It is hoped that there will be a large gathering to give Mr. Howard a worthy send off.

We publish in another column the balance sheet of Mr. T. Landon's Out-Patient Christmas Tea Fund. Of the surplus, amounting to £23 4s. 5d., it is proposed to give £8 4s. 6d. to the Maternity Samaritan Fund and keep the remainder as a nucleus for next year's entertainment and tea. The Committee desire to express their sincere regret for the loss of their Chairman, Mr. V. E. Collins, who has been such a great help to them in the past.

The University of Stuttgardt in returning thanks for the volume of Hospital Reports recently sent them, directed their letter to "Mrs. Dr. E. C. Perry & Co." The "& Co." is poor courtesy to Dr. Perry's fellow editor, but the "Mrs. Dr." is a touching acknowledgment of Dr. Perry's well-known domesticity.

To-night the employés of Butler's Wharf, under the name of the Excelsior Minstrels,

are giving an entertainment at Bermondsey Town Hall, Spa Road, in aid of the hospital. From what we hear it is sure to be a good show, and we hope as many Guy's men as possible will go down to encourage the minstrels in their charitable efforts.

CANDIDATES for the Treasurer's Prize of the Physical Society are reminded that their essays on the Pathology of Jaundice must be delivered to the Librarian not later than Wednesday, March 8th.

The Functions and Pathology of the Pituitary Body.

A Paper read before the Physical Society on Saturday, January 7th, 1899, by Mr. G. N. MEACHEN.

MR. PRESIDENT AND GENTLEMEN,—In the study of anatomy, whether human or comparative, the mere fact that a certain organ or part of such, the function of which is somewhat obscure, occupies a definite or even, perhaps, a prominent place in the animal economy, has been quite sufficient to invest it forthwith with powers little short of miraculous. At least, so thought many of the older anatomists, and really it can hardly be wondered that, in an age when the element of mystery exerted no small an influence even upon the minds of physicians and men of science, such conspicuous organs as the so-called "ductless glands" were accredited with somewhat startling functions. With the dawn of modern scientific research fled all the "humours," and suchlike imaginative products, fascinating no doubt to the credulous, but to the physiological truth-seeker these organs are slowly but surely becoming divested of their mysterious qualities, and functions, as definite as those of others more familiar, are being gradually assigned to each.

Some apology is needed for the subject which I have the honour to bring before your notice this evening, for it can neither be said that the functions of the Pituitary Body are wholly ascertained, nor that its pathological conditions are either constant or definitely established; but that it is not altogether "a disappointing organ to the physiologist," still less to the morbid anatomist, I shall endeavour to show, though, I fear, in rather a disconnected manner.

I need only briefly remind you of the anatomy of the pituitary body or hypophysis cerebri. It is suspended by means of the infundibulum from the anterior part of the floor of the third ventricle, and appears at the base of the brain as a small oval body, a little larger than a pea, immediately behind the optic chiasma. It weighs, upon the average, ·3 to ·6 grammes. Invested by a special process of dura mater, the diaphragma sellæ, it occupies the sella turcica on the dorsum of the sphenoid bone.

From its external appearance alone, one would not, perhaps, expect the pituitary body to be anything more than a mere terminal process of brain-matter, or, from its close proximity to the optic chiasma, that it might be connected in some way or other with the visual apparatus.

Its historical structure reveals at once the fact that it is made up of two distinct halves, a large anterior lobe and a small posterior one, which are often separated from one another by a narrow lymph-space. The anterior or glandular lobe is composed of polyhedral cells, grouped in alveoli, some of which contain colloid material, and surrounded by a connective-tissue stroma. In the posterior lobe are seen bundles of fibres crossing in every direction, together with scattered pigmented cells which were formerly regarded as imperfectly developed nerve-cells; but Berkeley has demonstrated by the Golgi method the presence of true nerve-cells having definite dendrites and axis-cylinder processes.

It is to the development of the pituitary body, however, that we look for a clue to its somewhat composite structure. In the human embryo at or about the third week, a process of the neural epiblast begins to grow downwards from the floor of the third ventricle (second cerebral vesicle). This is the infundibulum. At the same time, an invagination of the buccal epiblast occurs, the diverticulum of Rathke, which grows upwards towards the anterior surface of the infundibulum, with which it becomes intimately co-apted, though the cavities of the two processes do not communicate. The buccal diverticulum then dilates into a flask-shaped expansion in which a number of epithelial tubules become developed to the ultimate obliteration of its lumen. The communication with the pharynx is subsequently shut off. Nerve-cells and fibres become formed in the infundibulum, and the two processes are included in the same sheath of connective tissue.

The early connection of the anterior lobe with the mouth is rendered of special interest in the light of comparative anatomy by the fact that in *myxine* and *amphioxus*, an organ exists, known as the "subneural gland," which may be considered homologous with the pituitary. In these ancestral forms, the neural canal may be seen to dilate in the brain cavity into a distinct ventricle, the floor of which is connected with the exterior by means of a duct, lined by ciliated epithelium, which grows upwards from the buccal roof. Nerve-cells are collected round the neural opening of the duct, and epithelial cells around the lower or buccal opening. That a water-current passes throughout the whole central nervous system Andriezen has fully demonstrated by exposing these animals to a slow carmine stream, and observing that after a day the ventricle and whole length of the spinal canal right up to the posterior external opening (neurenteric canal) was filled with the carmine particles. This "water-vascular" current in these lower animals obviously serves the dual purpose of conveying oxygen to the tissues and of removing waste-products in a precisely similar way as the more elaborate and

later developed "blood-vascular" system. If such an extremely primitive system were to persist in the higher vertebrates, *e.g.*, among ourselves, the science of medicine would indeed be simple, since a dose of physic by the mouth would soon cure all nervous, respiratory, circulatory, and digestive troubles at one stroke, or, in other words, there would no longer be a "separate remedy for each disease!" Fortunately, we are of more complex construction. The buccal collection of epithelial cells forms a glandular structure which in higher forms is represented by the anterior lobe of the pituitary, and the nervous centre developed at the ventricular orifice of the duct is represented by the posterior lobe. This nervous part of the gland situated at the entry of the water-current would be sensitive to the quality of the water passing over it, and hence is analogous with the osphradial organ and ganglion of mollusca, which is placed at the entry of the mantle or respiratory chamber, and which is known to possess a water-testing function.

With the growth of "a blood-vascular" system, the necessity for the water current no longer exists. The pituitary duct, therefore, becomes obliterated, and the posterior, or nervous, lobe of the pituitary begins to lose its functions as we ascend the animal scale from *ammocœtes* upwards. Although in the human subject *nerve-cells still exist, no connection with the rest of the* brain, *viâ* the infundibulum, has yet been made out by processes of staining.

It is the anterior or glandular lobe of the pituitary, however, which is more important, and which in man *forms the greater part of the gland.*

Even in ancestral forms this lobe presents the typical structure of a secreting gland, and it is more than merely suggestive or accidental, that such a gland, situated at the entry of the water-current, could not but *pour its secretion into the duct, which would* be carried with the water stream through the central nervous system.

With the closure of the duct, the development of a "blood-vascular" system, and the consequent conversion of the pituitary into a "ductless gland," its secretion, which was once poured into the water stream, now becomes an "internal secretion," is absorbed by the lymphatics, and reaches the body-tissues by way of the blood-vessels.

Such is the account given by Andriezen of the evolution of the pituitary body.

The earlier anatomists were of the opinion that the pituitary received or collected the humours from the ventricles of them and excreted them in the nasal mucus—hence its name (Lat. pituita = mucus). The following quotations will suffice:—

"Sunt haec crassa viscidaque . . . efformavit, a quibus postea per anteriorem tertii ventriculi meatum tum per pelvim sensim ad glandulam pituitariam transmittit."—Spigelius.

"In quibusvis illorum omnes τοῦ ἐγκέφαλου ventriculi qualescunque fuerint aperturas versus infundibulum dehiscentes habent."—Willis.

In the higher vertebrates the boundary zone between the two lobes of the pituitary is all that remains of the pituitary duct, though it is almost invariably cystic in structure. In the rabbit these cystic spaces have been seen to be lined by ciliated epithelium, and sometimes in man large ciliated cysts are observed. No epithelial connection has been described between the gland and the pharynx in the adult human subject, but Luschka mentions a case of miscarriage with a spina bifida in which the pituitary was prolonged into the sphenoid and there existed an invagination of the mucous membrane on the opposite side.

Attempts at removal of the pituitary with the hope of thereby obtaining a more accurate knowledge of its functions have been made by Horsley, Marinesco and Gley, but with results for the most part negative. More recently Vassale and Sacchi have excised or destroyed the gland in dogs, using among other means injections of chromic acid. With complete removal or destruction the following symptoms were observed and were fairly constant:—

(1) Permanent fall of body-temperature.
(2) Anorexia and listlessness.
(3) Fibrillary twitchings and tremors of the muscles.
(4) Muscular spasms and cramps.
(5) Periodic attacks of dyspnœa.
(6) Rapid progress towards death.

Many of these symptoms improved when the animals were fed with pituitary extract.

It is remarkable to observe how closely the above experimental symptoms coincide with those deduced by Andriezen upon purely morphological considerations.

It is evident, therefore, that the pituitary produces an internal secretion which, by itself or in conjunction with that of other ductless glands, is of profound importance mainly in the nutrition of the nervous and muscular systems.

Oliver and Schäfer have found that the chief result of intravenous injection of extract of pituitary is a marked rise of the blood-pressure. The effect is produced rapidly and the pressure is maintained for a longer period than is the case with supra-renal extract. The arterioles are contracted and the heart-beats are accelerated. The same experimenters consider that, because thyroid extract produces a contrary physiological effect, *i.e.*, of lowering the blood-pressure, therefore the pituitary and thyroid are not vicarious in function, as some would believe.

Evidence of the supposed association in function is furnished by the following facts:—

(*a*) The pituitary has been observed to enlarge after thyroidectomy in rabbits by Rogowitsch, Hofmeister and Gley.

(*b*) Increase of size of the pituitary has been noted in cases of myxœdema and sporadic cretinism in which the thyroid was atrophied or absent.

(*c*) The two organs have been found enlarged together by many observers in several morbid conditions.

ANALYSIS OF 54 CASES OF ACROMEGALY IN THE UNITED KINGDOM IN 1889–1899.

No.	Ocular symptoms.	Patellar reflex.	Albuminuria.	Glycosuria.	Temperature.	Thyroid.	Mental Condition.	Duration.	Sex.	Age.	Observer.
1.	Double optic atrophy	Present	None	Sugar 2 p.c.	Normal	Normal	Normal	3 years	Female	34	Rolleston
2.	Homonymous hemianopia	——	——	——	——	Enlarged	Dull	3 "	"	23	Broadbent
3.	L. temporal hemianopia	Normal	——	Present	——	R. lobe enlarg.	"	4 "	"	23	Bury
4.	None	"	None	None	98°–99°	Normal	"	10 "	"	42	Appleyard
5.	"	"	"	"	——	"	Normal	4 "	"	28	Barrs
6.	Nystagmus	——	"	"	——	Enlarged	Dull	3 "	"	27	Whyte
7.	None	——	"	"	——	Normal	Melancholic	2 "	"	36	Shiach
8.	"	Almost absent	"	——	——	L. lobe enlarg.	Dull. Delusions	1½ "	Male	54	Waldo
9.	Right optic atrophy & Left temporal hemianopia	——	"	None	——	Enlarged	Clear	13 "	Female	38	Ruttle
10.	None	Diminished	"	"	——	Normal	Normal	15 "	Male	40	Barclay & Symmers
11.	"	——	——	Diabetes	——	Enlarged	Dull	——	Female	35	Squance
12.	Double optic atrophy	Normal	Present	None	Normal	Normal	Normal	5 years	Male	30	Dreschfield
13.	"	——	——	——	——	Enlarged	Erratic	4 "	Female	18	Lynn Thomas
14.	Rt. temporal hemianopia	Absent	None	None	97·4°–100·4°	Normal	Dull	1½ "	"	26	Banks
15.	Dimin. visual fields	——	——	——	——	"	Apathetic	——	"	27	Caton
16.	Bi-temporal hemianopia	——	——	None	——	"	Dull	½ years	"	30	Ransom
17.	None	——	None	"	——	"	Irritable	3½ "	Male	34	Murray
18.	Bi-temporal hemianopia	——	"	"	——	"	Dull	5 "	Female	47	Ransom
19.	Early d. optic atrophy	——	"	Sugar 6 p.c.	97°–98·6°	Enlarged	Cheerful	5 "	"	34	"
20.	R. optic atrophy & left optic neuritis	Normal	Slight	None	98·4°–104·2°	Tender; not enlarged	Normal	3 "	"	33	Caton
21.	——	——	——	Diabetes	——	Enlarged	——	——	Male	23	Dalton
22.	Bi-temporal hemianopia and optic neuritis	——	——	——	——	Normal	Memory impaired	½ years	"	39	D'Esterre
23.	None	——	None	None	——	"	Irritable	18 "	"	45	Gordon
24.	——	——	"	"	——	——	——	10 "	"	40	Brown
25.	Optic atrophy	Absent	——	——	Subnormal	——	Apathetic	5 months	Female	11	Woolcombe
26.	R. temporal hemianopia	——	——	——	"	——	——	12 years	"	28	Bramwell
27.	Amblyopia	Normal	None	None	——	Can be felt	Depressed	18 "	Male	55	Dyson
28.	——	——	——	——	——	——	Normal	2 "	"	34	Hutchinson
29.	Discs pale	——	None	None	——	——	Cheerful	3 "	"	38	Benson
30.	None	Absent	"	"	99°–100·8°	Normal	Normal	14 weeks	"	37	Saundby
31.	"	——	"	"	99°	Not felt	——	1 year	Female	19	Redmond
32.	Bi-temporal hemianopia	Present	"	"	Subnormal	R. lobe felt	Normal	5 years	"	27	Bramwell
33.	D. optic atrophy	——	——	——	——	——	——	3 "	Male	34	Hadley
34.	Hypermetropia	——	Some	None	Subnormal	Normal	Intelligent	9 "	"	49	Middleton
35.	L. optic atrophy	——	"	"	"	——	Normal	3½ "	Female	34	"
36.	None	Normal	None	"	——	——	"	12 "	Male	29	"
37.	D. optic atrophy	——	"	"	——	——	Dull	14 "	"	52	Cowell
38.	None	——	——	Diabetes	——	——	"	——	"	36	Muirhead
39.	D. optic atrophy	——	None	None	Subnormal	Normal	Drowsy	½ years	Female	35	Roxburgh & Collis
40.	Slight exophthalmos	——	"	"	——	Enlarged and cystic	Normal	6 "	"	41	Godlee
41.	R optic atrophy	——	"	——	——	Not felt	——	4½ "	"	37	Hadden & Ballance
42.	Optic neuritis	——	"	——	——	——	——	——	"	28	Wilks
43	Discs pale	——	"	None	——	Can be felt	——	6 years	"	44	Fleming
44.	None	——	"	——	——	Normal	Normal	6 "	"	53	Silcock
45.	"	——	"	None	——	"	"	12 "	Male	56	Campbell
46.	D. optic atrophy	——	——	——	——	"	Memory impaired	½ "	Female	50	"
47.	None	Present	None	None	——	Not felt	Intelligent	¾ "	Male	50	Philipps
48.	——	——	——	Present	——	Small	——	——	"	39	Rolleston
49.	Vision defective	——	——	——	——	Enlarged	——	10 years	"	42	Paget
50.	None	——	None	None	Normal	Small	Apathetic	1 year	Female	19	Thompson
51.	D. optic atrophy	Absent	"	"	Subnormal	Normal	Deficient	15 years	"	37	Neal & Shattock
52.	Exophthalmos	——	——	"	——	——	——	25 "	Male	46	Campbell
53.	None	——	——	Some	——	Normal	——	20 "	Female	51	Ball
54.	Exophthalmos	——	——	——	——	"	——	2 "	"	30	Goldsmith

VIDE—MR. MEACHEN'S PAPER ON "THE FUNCTIONS AND PATHOLOGY OF THE PITUITARY BODY."

(*d*) Structural similarity. Histologically, as mentioned above, the anterior lobe of the pituitary presents many features of resemblance to the thyroid.

On the other hand, in a large number of cases of myxœdema gathered from all sources, including those of the Clinical Society's Reports for 1888, in which the pituitary was examined, no special pathological change in that gland was noted.

Mariet and Bosc have recently investigated the effect of feeding healthy men and animals with pituitary gland. No effect was produced by repeatedly feeding dogs with ox's pituitary. In healthy men no abnormality was observed when the gland was taken by the mouth, but subcutaneous injection led to slight fever and general malaise, lasting for twenty-four hours. In epileptics it increased rather than diminished the number of the fits, and produced in some a state of mental exaltation which was quite different from any mental aberration from which they had previously suffered.

Besides the production of an internal secretion, the nature of which still remains doubtful, the pituitary possesses yet another important function upon which considerable stress has been laid, quite recently, by Prof. Joffroy, viz., the control of the development of, and the relationship between, the osseous and the muscular systems.

As regards the pathology of the pituitary body, Littré, in 1707, thought it probable that a serious and lingering disease would be seen, due to obstruction and inflammation of the gland, which might be atrophied. Such an announcement may almost be said to be of the nature of a prophecy!

Wenzel, in 1810, endeavoured to connect epilepsy with diseases of the pituitary. Ward, in 1823, described a case of cancerous tumour of the pituitary producing amaurosis in a man æt. 38. Rokitansky, in 1850, classified the diseases of the pituitary into three main groups: (i.) anomalies in size, including atrophy and hypertrophy; (ii.) diseases of structure, including anæmia and hyperæmia; (iii.) adventitious growths, including cancer, tubercle, and the yellow, colloid exudation sometimes found in the interstices between the two lobes.

Michel, in 1855, related a case of tumour of the pituitary, and from it drew the following conclusions:—

a. That the pituitary was not an essential part of the brain.

b. That it was identical with the so-called "ductless glands."

c. That in morbid conditions of the gland, the most prominent symptoms would be amaurosis of both eyes, apathy and syncope.

Auché, in 1873, in his valuable monograph on the subject, stated that the only two symptoms which, by their constancy and rapid succession, would lead one to suspect a lesion of the pituitary, are headache and gradually increasing blindness.

In 1885, Bowlby described a vascular tumour of the pituitary in a young man, æt. 22, who had suffered from frequent fits for ten years before his death. In the same year, Hale White recorded a case of myoneuroma of the pituitary, which was the size of a filbert nut, in a boy æt. 12, and a carcinoma of the gland in a baboon was described by Goodhart.

But what is undoubtedly the most important question of all, and one which opens out a wide field both for speculation and research, is the connection between the morbid conditions of the gland and the interesting disease known as acromegaly.

No account of the pathology of the pituitary would be complete without a description of acromegaly, since it may be stated that some lesion of the gland has been invariably discovered in every case of this affection in which an autopsy has been made.

Acromegaly as a pathological entity was first described by Pierre-Marie in 1885. Its name signifies "large extremity" (ἀκρον, an extremity, μέγαλη, large). It consists essentially of a uniform enlargement of the extremities and the lower jaw, accompanied by dulling of the intellect, ocular symptoms, and a gradual progress towards death.

The first case of acromegaly ever described, though not, of course, recognised as such, was probably that quoted by Saucerotte in 1772, in an article entitled "Accroisement singulier en grosseur des os d'un homme âgé de 39 ans." This individual showed progressive enlargement of the extremities and the lower jaw, and was of a dull, heavy disposition.

Another case, which was undoubtedly one of acromegaly, was described by Chalk, in 1857, of a girl, æt. 18, who, from a fright, had sudden suppression of the menses, which never afterwards returned. Two years later she became dull of intellect, and ten years later the extremities and the tongue began to enlarge, such enlargement being speedily followed by that of the lower jaw. The latter deformity was so great as to interfere with speech and mastication. Her skin was dirty yellow, and amaurosis ending in total blindness quickly ensued. The case was at the time regarded as one of partial dislocation of the lower jaw from an enlarged tongue!

Recklinghausen proposed the name "pachyacria," signifying that the morbid change is a thickening of all the structures of the part involved, and not merely the extremities. But the term acromegaly or "Marie's malady," as it has been called in honour of the discoverer, has already taken too deep a hold upon the medical public to permit of any alteration in its nomenclature.

Marie described the disease as "an unusual non-congenital hypertrophy of the head and upper and lower extremities."

I will now briefly give an account of the symptoms, diagnosis, ætiology and pathology of acromegaly.

Symptoms.

The first thing usually noticed by the patient is the gradual increase in the size of the hands, feet and head. The hypertrophy includes all the tissues composing the hand and chiefly involves their width and

thickness. The fingers have been likened to sausages, but they are not quite cylindrical, being flattened from before backwards. The term "battledore hand" well expresses its appearance. The nails are small, flattened and widened. The arm and forearm remain normal. The feet are affected in a similar way, so that in the case of a female patient a visit to her bootmaker may be the first means by which she is apprised of the fact, possibly in language more forcible than polite!

The head also increases in size, but not uniformly. It is the face which presents the characteristic deformity, so that a case of acromegaly has been diagnosed in the street. The face is elongated and elliptical, and the orbits are thickened. The lower lip is hypertrophied and turned downwards. There is often macroglossia and the tonsils and uvula are enlarged. The chin is large and massive, forming a distinct projection downwards and forwards; this symptom is known as prognathism.

The cartilages of the nose, ear and larynx, also become enlarged.

A certain amount of cervico-dorsal antero-posterior curve or kyphosis is almost always present. The clavicles and ribs are enlarged, and the lower ribs may even touch the iliac crests in the sitting posture. It will thus be seen that two humps are formed, one in front of the thorax and one behind, which Marie states resemble those represented on the figure of "Punch."

The thyroid is very variable. In the majority of the cases it is diminished in size, though it may hypertrophy or remain normal.

Owing to the thickening of the cricoid and arytenoid cartilages, the voice is modified in a peculiar way, becoming almost always deeper and harsher.

Erb and Verstraten have described an area of dulness over the upper sternal region, which they attribute to the presence of a persistent thymus; but there does not seem to be much foundation for such a view.

The female external genitalia may exhibit great hypertrophy, while the uterus shows signs of senile changes. Amenorrhœa is frequently the first phenomenon in the development of acromegaly. The mammæ may be atrophied, while the nipples are large.

The male external genitalia are variable, some cases presenting hypertrophy and others atrophy. Loss of virility is generally a constant symptom.

The muscles may at first hypertrophy with a corresponding increase of muscular power, but later on the patient becomes feeble.

The tendon-reflexes are usually present, but may be diminished or absent; they have not been found increased.

In the cardio-vascular system, the heart is hypertrophied, the arteries sometimes atheromatous and the veins varicose.

There is hyperidrosis and the hair becomes thicker and more abundant.

There may be polyuria, either alone or combined with glycosuria. Albuminuria is occasionally present.

The skin may be of a yellowish tint, and in general seems too large for the body. Molluscum fibrosum growths are common. There is usually a thickened pad on the inner side of the plantar surface of each foot.

The temperature is subnormal. Headache is constant and may be severe. The sight is nearly always affected, the lesions varying from slight amblyopia to complete amaurosis. The physical signs observed are optic neuritis or atrophy, or a narrowing of the visual field.

Other less constant symptoms are thirst, deafness, tinnitus aurium, exophthalmos and anosmia.

The mental condition may be normal, or there may be apathy, somnolency, irritability or melancholia.

Diagnosis.

1. The most important diagnostic points in *acromegaly* are the uniform enlargement of the hands and feet involving both the bones and the soft tissues; the small size and flattening of the nails; the hypertrophy of the inferior maxilla giving the characteristic prognathous appearance; the kyphosis; the ocular symptoms; the hyperidrosis, and the thick, coarse hair.

2. In *hypertrophic pulmonary osteo-arthropathy* the fingers alone are affected; the nails are "parrot-beaked"; the bones alone are hypertrophied; there is no affection of the lower jaw, and the disease is always secondary to some lung affection, especially some or other suppurative change.

3. In *myxœdema* there is the peculiar "full-moon" appearance of the face; the skin is waxy; the skeleton is unaffected, and there is anidrosis and alopecia.

4. In *osteitis deformans* the skeletal changes are most manifest in the cranium; the extremities are scarcely ever affected.

5. In *leontiasis ossium* there is actual bony growth of the cranium and face, while the extremities usually remain normal.

6. In *arthritis deformans* the joints are alone affected and not the extremities.

7. In the disease which was named *erythromelagia* by Weir Mitchell there is occasionally some increase in the size of the fingers and a slight degree of kyphosis, but the cranial symptoms are all absent.

Prognosis.

This must be considered, upon the whole, bad, for, although the symptoms may be held in check by suitable treatment for some time, or may even remain in abeyance for a lengthened period, yet the general progress of the disease is in a downward direction.

With regard to the duration of the disease, three types have been recognised by Sternberg:—

(1) The benign, which may last for fifty years and cause little or no discomfort.

(2) The ordinary chronic type, lasting from eight to thirty years, which is the commonest variety.

(3) The acute, malignant type, with death occurring in three to four years.

Ætiology.

The knowledge of the causes of acromegaly is still indefinite. The influence of heredity is stated by Marie

to be unimportant, but Schwoner relates a case of acromegaly in a woman æt. 53, whose parents were both remarkable for their size and whose mother was also acromegalic.

With regard to sex, contrary opinions have been expressed. Souza-Leite considers that it occurs rather more frequently in women than in men In 54 cases which I have been able to collect, occurring in the United Kingdom during the last ten years, 22 were males and 32 females.

Age, however, is of more importance. Marie states that acromegaly is not congenital, and is not observed in children, but that it commonly makes its first appearance between the ages of 18 and 26. Massolongo has described a case of true acromegaly in an infant of fourteen months. This child, besides being a microcephalic idiot, was afflicted with aphasia, paraplegia, internal strabismus, nystagmus, polyuria and bi-lateral atrophy of the neck. The case is regarded as unique! Surmont, also, quotes the case of a girl, æt. 14, who contracted a chill at the time of the first appearance of the menses. These were abruptly surpressed, and from that time the child began to grow out of all proportion to her years, the extremities and face particularly taking part in the general hypertrophy. Later on, severe headache, accompanied by double optic neuritis, supervened, until the whole case presented the typical aspect of acromegaly. On the other hand, in Erb's case the disease did not appear till the age of forty-eight, at the time of the menopause.

I do not know what has not been given as a predisposing or exciting cause of acromegaly. Mental emotions, rheumatism, gout, syphilis, alcohol, the exanthemata and traumatism have all been quoted as factors in the causation of the disease. Unverricht, impressed with the exciting influence of injuries to the head upon the development of acromegaly, asks that, as "traumatic" leuchæmia, ulcerative endocarditis and diabetes are recognized, whether there may not be such a thing as "traumatic acromegaly"?

Pathology.

Of 34 autopsies upon cases of acromegaly collected by Furnivall, some lesion of the pituitary was found in every one. In 31 the gland was enlarged either by simple atrophy, new growth, or degenerative changes; in the remaining three, the gland was diseased without being enlarged.

The question arises as to what is the nature of the morbid change in the pituitary which gives rise to such a complex set of symptoms which we find in acromegaly.

We have seen how that the main function of the pituitary is to produce an internal secretion which has for its object the preservation of the balance between the osseous and the muscular systems; therefore it is not unreasonable to suppose that the symptoms of acromegaly are due to some alteration in the internal secretion of the gland. Rolleston considers that this secretion may be modified in three ways:—

(1) *It may be suppressed.*—According to this view, acromegaly would be analogous to myxœdema or Addison's disease, and in order to cause such suppression the gland must be either atrophied or destroyed by a tumour. But the pituitary has been almost always found to be enlarged. Feeding with pituitary extract should cause amelioration of the symptoms, but such treatment, in so far as it has been tried, has not always met with success.

(2) *It may be excessive.*—As the morbid changes in the gland are frequently seen to be those of simple hypertrophy, it might be expected that the symptoms are due to hypersecretion. Accordingly, feeding with pituitary extract should aggravate the symptoms, but such has not been the case.

(3) *It may be perverted.*—It is probable that some toxine is produced in the abnormal secretion itself or by interfering with the proper action of other internal secretions, which stimulates the tissues to overgrowth. Marie suggested that in the disease known as hypertrophic pulmonary osteo-arthropathy, which in many points resembles acromegaly, the changes in the extremities might be due to the absorption of a toxine from the lungs. The apparent failure, or at any rate the small success, of pituitary extract in the treatment of acromegaly suggests that the disease is due to perverted excretion rather than to its aggravation or suppression. This view is also shared by Marie and Marinesco.

But of the precise manner in which the secretion is altered we are still ignorant. Schiff has recently found that the administration of pituitary extract increases the elimination of phosphoric acid (? due to the decomposition of bony tissue) in a marked fashion, which fact, he thinks, might explain the inverse phenomenon of hypertrophy of bony tissue in acromegaly through hyperactivity of the pituitary.

The mere presence of a tumour in the pituitary will not necessarily produce acromegaly as several recorded cases have shown.

Besides the "pituitary" theory of acromegaly, which is now the one most generally accepted, because most supported by facts, Campbell has endeavoured to show that acromegaly is a reversion to an ancestral type. This may be called the "reversion" or "atavistic" theory. Dr. Campbell traces the resemblance between the acromegalic man and the anthropoid apes, arguing upon the theory that in morbid processes, especially those of dissolution, ancestral peculiarities are being continually laid bare. A point of interest in his description is that in the adult gorilla the sella turcica is very large, indicating that the pituitary is therefore also large.

Woods Hutchinson finds also on comparing the skulls of the anthropoid apes, that the gorilla, "who, in jaws, frontal sinus, hands, feet and dorsal kyphosis is almost ludicrously 'acromegalic,' has in five specimens out of six the characteristic large bowl-shaped pituitary fossa." But, on the other hand, there is no evidence to prove that the pituitary in the gorilla is morbidly affected, or

that the animal ever shows any of the constitutional and more dangerous symptoms of acromegaly as it is seen in man.

A "nervous" theory was, at one time, proposed by Klebs, on the ground that the sympathetic system has been found diseased in some cases, but it has been since discarded. In this connection, Middleton describes a case of acromegaly in which there were trophic lesions of the joints, suggestive of analogies with Charcot's joint-lesions.

With reference to the connection between the central canal of the cord and the embryonic intestinal canal, it is specially noteworthy that a case of acromegaly combined with syringomyelia, and presenting the characteristic features of both diseases, has been described by Peterson.

It may be remarked that no one has yet advanced a microbic theory of acromegaly.

Another very interesting theory, which is supported by facts, has been brought forward by Brissaud, viz., that acromegaly and *gigantism* are but greater and lesser manifestations, respectively, of the same morbid process. He states that it is not uncommon for persons above the medium height to exhibit some of the deformities characteristic of acromegaly, but that although some giants are acromegalic, yet all acromegalics are not giants. He further adds that primary hypertrophy of skeleton and secondary enlargement of the soft tissues are produced in a definite period of tine, and then the osteogenic process is arrested. The following are the conclusions at which he arrives:—

1. If this time of overgrowth occur during childhood and youth, the result is gigantism and not acromelagy.

2. If it occur in the adult, *i.e.*, in a time in the life history of the individual when development has ceased to progress, the result is acromegaly.

3. If, after having reached the time of growth in which the height of the individual still continues to increase, this period encroach upon that phase of existence which is no longer compatible with bony development, the result is a combination of gigantism and acromegaly.

Prof. Joffroy, as mentioned above, is another exponent of this theory. He considers that "whenever there is an increase in the activity of the pituitary, by reason of a congestive or inflammatory process, there is a more marked development of the osseous and muscular systems, and the result is that the young individual becomes a giant, the fully-developed person a case of acromegalia." Further proof of pituitary influence as a factor in the production of gigantism, with or without acromegaly, has been offered by the examination of the skeleton in giants. Unfortunately, such examinations have been few and generally unreliable. One of the best examples is the case of the Irish giant, Cornelius McGrant (1720), who was affected with acromegaly and whose skeleton is preserved at Trinity College. The sella turcica was enlarged so that it would contain a walnut.

Apart from the changes in the pituitary, there are certain points in the extremities to which attention has been directed. Marinesco found that in the great toe all the structures were hypertrophied, even the membrana propria of the sebaceous and sweat glands. The nerve-sheaths of the subcutaneous nerves showed great increase in thickness, as did also the external coat of the blood-vessels. M. Gilbert has recently invoked the aid of the Rontgen rays in a case of acromegaly, which show that hypertrophy is manifested in the bones as well as in the soft tissues. The enlargement of the bones is most marked in the neighbourhood of the epiphyses, while the phalanges present numerous irregularities to which M. Barthélemy has given the name of "osseous stalactites." The skiagraph of the thorax revealed a distinct shadow above that produced by the heart; this was taken to indicate an enlarged thymus, and corroborates the results obtained by Erb.

Next to the pituitary the organ most commonly affected in acromegaly is the thyroid. In my 54 cases, enlargement of the thyroid was observed in 14 during life, and in 1 the gland was tender but not enlarged. The post-mortem appearances of the gland are very variable, sometimes being atrophied, at others showing simple hypertrophy, and frequently presenting no change whatever.

Murray quotes five cases in which acromegaly and exophthalmic goître have existed together, the patient showing typical signs of the two affections. In the above 54 cases exophthalmos was noted in 3, but in 2 of these the thyroid was not stated to be enlarged.

These facts, together with the effect of thyroid feeding in acromegaly, lend strong colour to the view that it is not so much the internal secretion of the pituitary which is at fault, but that its secretion is somewhat inter-dependent upon that of the thyroid. In health the internal secretions of the two organs work harmoniously together, but if one is in any way deranged the other endeavours to compensate for the deficiency with unsuccessful or even disastrous results.

Another point, quite as important as the connection between the pituitary and the thyroid, is the occasional occurrence of diabetes in acromegaly. Loeb, in 1884, drew attention to the association of glycosuria with tumours of the pituitary, for which he accounted by pressure upon the brain. Hausemann has recently found that in 97 cases of acromegaly recorded in medical literature, diabetes was present in 12; but in some of these, pancreatic changes were observed which might be regarded as the possible cause of the glycosuria. In the above 54 cases glycosuria or diabetes was recorded in eight, or 14·8 per cent., which is a little higher figure than that given by Hausemann. It may be noted that experimental removal of the pituitary in animals has not been followed by glycosuria. Strümpell quoted a case of acromegaly in which the diabetes disappeared and returned again. Loeb considered that this was due to an alteration in the size of the pituitary tumour, and curiously enough confirmatory evidence was given by

the autopsy, which showed that the tumour was an angio-sarcoma. It may be that the internal secretion of the pituitary is interdependent upon that of the pancreas, as it has been supposed to be upon that of the thyroid, and thus the diabetes may be due to the secondary impairment of function of the pancreas. We cannot explain, though, why it should occur in some cases of acromegaly and not in others.

The supra-renals are not affected in acromegaly.

Treatment.

As the pathology of acromegaly is still more or less uncertain, the treatment must necessarily be empirical and symptomatic in proportion.

For the intense headache, valerianate of caffeine and phenacetin have been found beneficial. Antipyrine, arsenic, the salicylates and the iodides have been administered, either alone or alternately, and in some cases these drugs have apparently held the disease in check.

In a few instances trephining has, by lessening the general intra-cranial tension, caused more or less permanent relief of the severe headache and feeling of tightness of which the patients often complain. Meanwhile, glycosuria must be overcome, when it arises, and the patient's strength must be supported by plenty of suitable nourishment.

More hopeful results have been obtained by the administration of pituitary extract, on the theory that by so doing, the deficiency of certain elements in the internal secretion of the gland will be made up; but it must be admitted that the effect of such administration is by no means constant and in some cases even disappointing. As far as statistics go, Kinnicut found that in 13 cases of acromegaly treated with pituitary extract, 7 showed varying degrees of improvement, 5 none, and 1 became worse. In 2 the violent headache and neuralgic pains in the limbs were diminished. Decrease in size of the extremities occurred in one case.

In a case recorded by Caton (No. 15), three tablets containing two grains of pituitary body were given daily. As her condition remained variable, thyroid tablets were alternated with pituitary after the interval of one month. Improvement then became rapid, vision was restored, the extremities diminished in size, and the apathetic condition of mind gave way to one of cheerfulness. How much of this was due to the thyroid and how much to pituitary it is difficult to say.

Still, we should not be discouraged even by apparent failures, for the administration of animal extracts in certain diseases surely seems reasonable, and in some it has met with conspicuous success. It is evident, therefore, that the more we know of the physiology of the internal secretions the more truly scientific will our treatment by these means become.

Incomplete as our knowledge of the pituitary still remains, yet enough, I venture to think, is already known to make it appear that the gland is not merely a fœtal relic, but, from its very persistence from the lowest vertebrates up to man, that it is endowed with special functions of its own, and is liable to morbid conditions in the same manner as other internally secreting glands.

My thanks are due to Dr. Hale White for the loan of microscopic specimens.

Note.—Since the completion of this paper my attention has been called to the possible connection between some pathological condition of the pituitary and the tropical malady known as "sleeping sickness" (*vide* B. M. J., Dec. 3rd, 1898). Dr. Patrick Manson, in his interesting lecture, quotes one case in which the pituitary was found at the autopsy to be enlarged by old blood-clot. In other *post-mortem* examinations lesions of the gland have not been observed. It appears most probable that the disease is due, not to a gross cerebral lesion, but to the presence of the *filaria perstans* in the blood, which operates primarily upon the brain.—G.N.M.

CHIEF BIBLIOGRAPHY.

Andriezen. Brit. Med. Journ., 1894. i.
Auché. "Sur la glande pituitaire et de ses maladies." Poitiers, 1873.
Boyce and Beadles. Journ. of Path. 1893. i.
Brissaud. Rév. Scient., Paris, 1895. 4, s. iii.
Gilbert. Compt. rend. Soc. de Biol., Paris, 1898. 10, s. v.
Marie and Souza-Leite. Essays, New Syd. Soc., 1891.
Massolongo. Rév. Neurolog., 1895.
Oliver and Schäfer. Journ. of Physiol., 1895. xviii.
Saucerotte. Mélanges de Chirurg., 1801. i.

Appointments.

CIVIL.

Colman, Ernest, M.B., B.S. Lond., has been appointed Assistant Medical Officer for the County Asylum, Rainhill, near Liverpool.

Jones, Charles Sturges, M.R.C.S., L.S.A., has been re-appointed Medical Officer of Health for Chichester.

Mayston, R. W., M.B. Lond., M.R.C.S., L.R.C.P., has been appointed House Physician to the Dreadnought Seamen's Hospital, Greenwich, S.E.

MacConkey, A. A., M.B., B.C., D.P.H. Cantab., has been appointed Assistant to the Bacteriologist of the Royal Commission on Sewage Disposal.

Weekes, C. P., L.R.C.P. Lond., M.R.C.S., has been appointed House Surgeon to the Boscombe Hospital, Bournemouth.

NAVAL AND MILITARY.

Surgeon Norman L. Richards, R.N., has been appointed to the *Northampton* additional for the *Curacoa*.

Captain W. G. Beyts, R.A.M.C., has been appointed Surgeon on the Staff of his Excellency the Commander-in-Chief in India.

Sport.

Rugby Football.

GUY'S v. KENSINGTON.

This match was played at Wood Lane on Saturday last. Though rain fell in the morning, the afternoon cleared up beautifully, and a well contested game was played on a fairly dry ground. For off-side play by one of the opposing half-backs soon after the start, we were given a penalty in a good position; from this O'Brien kicked a pretty goal. For most of the time we pressed, and Jackson should have scored, but in trying to run round he went into touch in goal. The Kensington three-quarters tackled well, and Pretty several times brought down our men when a try seemed probable. No further scoring took place until half-time.

About ten minutes after the re-start some good passing among their three-quarters ended in the wing man scoring a try, which was not converted. Play after this became much keener. Moore should have scored for our opponents, and Trail got over the line for us, but was called back. During the last few minutes play became exciting, and although for some time in their twenty-five, we failed to score, and the game was left drawn with three points aside. Team:—

GUY'S.—G. Evans (back); F. L. Rae, F. W. Sime, C. T. Hilton, A. O'Brien (three-quarter backs); M. C. Wetherell, F. D. S. Jackson (half-backs); R. C. Mullins (Capt.), D. H. Trail, A. A. Smith, T. P. Thomas, P. T. Manson, K. V. Trubshaw, A. H. Wall and R. C. Lawry (forwards).

GUY'S v. ST. THOMAS'S.

INTER-HOSPITAL CUP.—2nd Round.

Tuesday's was a splendid afternoon down at Richmond, and the big ground was in first-rate condition, and not too hard to fall on. What wind there was blew right across the ground, so that winning the toss meant no material advantage to Guy's. After the photographic fiend had done his worst and kept the thousand spectators waiting an extra ten minutes, the teams took the field as under:—

GUY'S.—G. Evans (back); F. L. Rae, A. O'Brien, F. W. Sime, C. T. Hilton (three-quarter backs); F. D. S. Jackson, M. C. Wetherell (half-backs); R. C. Mullins T. P. Thomas, D. H. Trail, A. Ayre-Smith, H. A. Cutler, P. T. Manson, K. V. Trubshaw, A. H. E. Wall (forwards).

THOMAS'S.—H. Wheelwright (back); H. G. Pinches, L. F. Hanbury, A. H. Greg, R. Bridges (three-quarter backs); H. M. Harwood, E. T. Holland (half-backs); A. E. Martin, R. J. C. Thompson, T. W. Downes, G. H. Latham, H. G. Stevens, J. Little, T. S. Taylor and J. F. Cunningham (forwards).

Referee: Mr. P. Coles (L.R.U.S.R.). Linesmen: F E. Walker and E. W. Browne.

Martin kicked off for Thomas's, and after kicks had been exchanged, the first scrum was formed close to the half-way line. For the first quarter of an hour, although the game was fought out in Thomas's territory, Guy's did not show any marked superiority. The forwards soon settled down, and Jackson and Wetherell handed the ball out well, but faulty passing by the third row—Sime being the chief offender—prevented any scoring for some time. Thomas's tackling, too, was very deadly. Sime was beautifully tackled with the ball by Hanbury, and Greg stopped Rae within ten yards of the line. From a good passing run, Hilton should easily have been in, had he received anything like a decent pass. Guy's forwards were then conspicuous for some good dribbling, and a scrum was formed five yards from the Thomas's posts, Greg having been compelled to take the ball over his own line. Martin and Thompson, however, relieved nobly, and play was transferred to the twenty-five line. Thomas's wheeled the next scrum, but Wall got round and stopped the rush splendidly. Directly after the Thomas's line was crossed in a loose rush, but the ball went into touch in goal. The drop-out was well returned by Sime, and then Thomas's back failing to field the ball, Sime snapped it up and handing to Rae at the opportune moment, the latter scored behind the posts, and O'Brien converted. This occurred twenty minutes from the start. Kicking off again, Thomas's made a little ground Evans being called upon for the first time, and kicking into touch just beyond Guy's twenty-five line, the ball was quickly rushed back to the half-way, and a further good piece of dribbling by Jackson and Wall took the ball another twenty yards. Here a scrum was formed and Jackson handing out to Wetherell, he made some ground, and passing to Sime enabled the latter to score rather wide out. T. P. Thomas' attempt to improve was not successful. Soon after the drop-out the game was stopped for a few minutes' owing to Stevens receiving a blow which made his nose bleed rather freely, but he was able to continue. And now for the first time Thomas's threatened serious danger. Several scrums were formed near the Guy's twenty-five line, and Thomas getting the ball out, it was only the excellent tackling of Jackson and Wetherell that prevented them from making a lot of ground. It was just at this time that Evans in attempting to stop a loose rush twisted his knee, and had to be assisted off the field. This necessitated a re-arrangement of the backs, Hilton going full-back, Sime to the left wing, and T. P. Thomas coming out of the pack to centre three-quarter. Although one forward short, Guy's carried the next two scrums somewhat easily, and play was taken back to the half-way. Hanbury made his mark, but Thomas with a fine kick sent the ball over the goal-line, and a touch-down resulted. From the drop-out O'Brien made a lot of ground with a splendid kick, and Guy's again held the upper hand. A loose rush ended in Wheelwright making a bad kick into touch, but Martin, Cunningham and Downes effected a good dribble and relieved. Soon after the whistle sounded for half-time, the score standing—

Guy's, 1 goal 1 try (8 points).
St. Thomas's, nil.

Very soon after the restart the best bit of passing of the match took place. Wetherell passed out to Jackson, and he sent the ball to Thomas. Going at full tilt he gave a long pass to O'Brien, and he, timing it beautifully, sent it out wide to Rae, whose pace enabled him to score easily, but rather wide of the posts. No goal resulted. Guy's now had a great deal the better of the game, keeping up a perpetual attack on their opponents' line. Sime nearly scored on the left on two occasions, but was splendidly stopped by Greg each time. From the second of the resulting scrums, Ayre Smith and Cutler, getting the ball between them, took advantage of the diversion caused by the halves all appealing for off side, and had a quiet maul in goal, which ended in Cutler gaining a try. T. P. Thomas landed a fine goal from the touch line. After the kick off, Guy's quickly returned to their opponents' territory, and Sime, not to be had a third time down in the corner, doubled in and scored a good try midway between the posts and the touch line, O'Brien taking the kick successfully. Thomas's soon after obtained a free kick for some informality, in a favourable position, but it was charged down and the danger so averted. Almost immediately afterwards, Guy's had a kick awarded for "foot up," and soon after, Rae, following up smartly, fielded the ball and got clean away, but when close to the line was brought down by Greg, a splendid effort. Hilton was then conspicuous for an excellent run from full back; he passed several opponents and then passed to Sime. Greg intercepted, but only knocked the ball back, and Sime, fielding it, gained an unopposed try behind the posts, which O'Brien easily converted. Thomas rushed to next scrum, and for the first time in the game Guy's were compelled to save behind their own line, Hilton kicking the ball dead in the nick of time. The closing stages of the game were fought out in midfield, no further scoring occurring, and the whistle sounded, leaving Guy's easy winners.

Guy's, 4 goals and 2 tries (26 points).
St. Thomas's, nil.

REMARKS.—The forwards were all good. Even when one short they easily beat the opposing pack. The dribbling showed a marked improvement on previous matches, and the following-up was as keen as one could wish. At the line-out, too, ground was gained by them on several occasions. Jackson and Wetherell were better than their opponents, but, of course, they played behind winning forwards They were quicker at passing the ball out in the first half than the second, but all through their tackling and saving was above reproach. The three-quarters had plenty of opportunities, and, perhaps, ought to have scored even more than they did, for their passing at first was rather feeble. O'Brien was, all through, a brilliant exception. His play was admirable, he kicked with great judgment and timed his passes beautifully. Thomas, though new to the position, proved himself a worthy confrère, kicking and running with great power. Evans was very unfortunate in being injured in doing almost the first bit of work he was called upon for. He has our sincerest sympathy. Mr. Percy Coles proved himself an admirable referee.

Thomas's were unfortunate in being without either of their regular halves, their absence necessitating Harwood going up from the three-quarter line and giving Holland another opportunity. The former did a fine lot of saving, he, Hanbury and Greg doing most of the defensive work. The last-named saved three, if not more, certain tries. Martin, Cunningham, Downes and Thompson appeared to be the best of their forwards.

Association Football.

GUY'S 1st XI. v. READING AMATEURS.

Played at Reading on a fast and lively ground. Guy's started against the wind, and at the start the game was fairly even. Gradually Reading got considerably the better of the game, and after several shots had gone over, a long shot took effect through the goal-keeper failing to pick up cleanly (1–0). The game in the second half was, on the whole, against Guy's, their forwards rarely attempting to pass the heavy and powerful backs against them. Towards the finish the inside left scored with a shot few goalkeepers could stop. The game was poor, and Guy's were much hampered by the wind and liveliness of the ground. Individually "Old-un" played well, but was inclined to wander too far forward, and into the wings. The two backs, of whom Matthews played a sound game, do not know when to lie up to their halves and when to fall back. In the second half especially, playing with the wind, they both lay so far back that the forwards were able to receive and start unhampered with the halves in hopeless pursuit. Shepherd and his half muddle a good deal between them, through not having a thorough understanding between each other. Langdale was the best of the forwards but must look where he passes and not lavishly feed his outside each time he receives the ball. The modern tendency is for the forwards to keep closer in the centre, and to practice short passing there, especially when near goal, and long passing through the half to the outside, who must never come in to the centre unless he is running clear away from the opposing backs. The duty of an outside is to lie close to the line ready to slip away from his half and take a long pass forward. He should always middle at once within the 25 yards, and on the run, never stopping to take it back and never shooting from the wing. Peall has absolutely no dash, rarely middles on the run, and should pass to the inside right with a long lift rather than risking a wild shoot from the wing. Roberts is mechanical and never attempts to dash through, a fault common to all the forwards. Team:—

GUY'S.—F. M. V. Smith (goal); J. Matthews, N. P. Shepherd (backs); R. W. B. Hall, O. L. Dunn, J. M. Brydone (halves); H. L. Dent, N. Langdale, W. O. Roberts, S. C. Morris, P. A. Peall.

GUY'S 2ND XI. v. BANSTEAD.

Played at Banstead on Saturday, February 11th. In spite of the bad weather the ground was in excellent condition, and a close game resulted in a draw (1–1). Guy's won the toss and started downhill with the wind; the rushes by our forwards were effectually checked by the opposing back division. There was a lack of combination among the forwards, whilst their individual play was at times brilliant. Although we had the best of the game during the first half there was no score up to half-time.

Camps scored for us soon after the interval, and to within a quarter of an hour of time the game was very even. Then one of our forwards had to retire and almost immediately they scored through some mistake in the back division, and we were on the defensive for most of the rest of the game. Team:—

GUY'S.—E. T. Heap (goal); J. S. Turner and P. V. C. Bent (backs); P. P. Cole, D. G. Greenfield, A. H. Smith (half-backs); —. Turner, L. J. Hughes, H. K. Lacey, B. Rust and P. W. L. Camps (forwards).

Since the Junior Inter-Hospital Cup matches are so close, a few remarks would not be out of place. If the forwards would train properly they would be twice as useful as at present, as they are very fast, and at times combine well; they do not drop back enough to help the halves. The halves must follow the forwards up, more especially during rushes. The backs and goal-keeper would improve with training.

United Hospitals Hare and Hounds.

UNITED HOSPITALS H. & H. v. OXFORD UNIVERSITY H. & H.

The Hospitals were poorly represented at Oxford on Saturday, only four men turning out, of which Mary's supplied three. R. E. Brayne was prevented at the last moment from turning out on account of influenza. The match ended in an easy victory for Oxford University by 10 points to 26. Although the wind was high the going was good, and the course went over very little plough. Stooke-Vaughan, Briscoe and Davis drew away after the first mile, and gradually increased the distance between them and those behind to the finish. Easton kept in front of Banbury nearly all the way, but was overtaken about a quarter of a mile from home The course was about six and three-quarter miles. The following was the order of arrival:—

	Min.	Sec
J. S. Stooke-Vaughan (Oxford)	48	4
H. R Briscoe (Oxford)	48	4
H. S. Davis (Oxford)	48	58
H. N. Banbury (Oxford)	50	20
P. G. Easton (Hospitals)	50	31
R. S. Roper (Hospitals)	52	36
N. E. Waterhouse (Oxford)	54	30

McCowen and Tullock were not timed.

Chapel News.

The Bishop of Rochester has very kindly promised, in his capacity as chaplain of the hospital, to hold a Confirmation in the chapel on Monday, March 6th, at 6.15 p.m. The service will be quite short, and no doubt many who are too busy to go to a long service will be glad to avail themselves of this opportunity of seeing and hearing the Bishop.

During the week-days in Lent, evening prayer will be said daily in chapel at 5 o'clock, except on Ash Wednesday and Good Friday, when it will be said at 8.15 p.m. This will be continued as a permanent arrangement if the attendance at the service justifies it.

The preacher at the 7 p.m. service on the Sundays in Lent will be the Rev. L. B. Staden. The Rev. F. H. Rice will give the instructions on Tuesday evenings at 8.15 p.m., beginning Tuesday, February 28th.

Births.

BIGGS.—On Thursday, February 9th, at 147, Newport Road, Cardiff, the wife of J. J. E. Biggs, M.R.C.S., L.R.C.P., of a son.

OSBORN.—On February 7th, at the Châlet, Dover, the wife of Arthur Osborn, M.R.C.S., L.R.C.P., of a daughter.

PRALL.—On February 15th, at Rochester House, Bampton, Oxfordshire, the wife of J. Henniker Prall, L.R.C.P. Lond., and M.R.C.S. Eng., of a daughter.

Marriages.

CLARKE—GEE.—On January 19th, at St. John the Baptist's Church, Leicester, Astley Vavasour Clarke, M.D. Cantab, Enville House, Leicester, to Ethel Mary, eldest daughter of H. Simpson Gee, J.P., of Knighton Frith, Leicester.

HAMILTON—ELLIOTT.—On January 2nd, at Newcastle, Natal, by special licence, Edward Thomas Ernest Hamilton, M.D., M.S., F.R.C.S., of Johannesburg, second son of the late Mark Hamilton, M.D., R.N., to Marian Helen Elliott, of Cairo, Egypt, youngest daughter of the late Charles Elliott, Esq., of Abberley, Worcestershire.

HUCKLE—FARNFIELD.—On January 12th, at St. Matthew's, Brixton, A. H. Hedley Huckle, L.R.C.P. Lond., M.R.C.S., L.D.S. Eng., to Grace Shore, only daughter of the late Dr. Walter E. Farnfield, of Brixton Road, S.W.

WOHLMANN—MADDEN.—On January 10th, at St, John's, Blackheath, S.E., Arthur Stanley Wohlmann. M.D. Lond., of Gay Street, Bath, to Eugenia E. H. Madden, widow of the late Colonel Madden.

Death.

BLASSON.—On January 17th, at Bourne, Lincolnshire, George John Blasson, M.R.C.S., L.S.A., aged 61 years.

ED.—H. L. E.

Contents.

	PAGE
CARCINOMA OF THE STOMACH: Clinical Lecture by Dr. Hale White	93–98
HOSPITAL NEWS	98–99
CASE FOR DIAGNOSIS	99–100
A CASE OF ACUTE PERIPHERAL NEURITIS	100–101
PAPERS BY GUY'S MEN	101
A CASE OF CÆSAREAN SECTION	102
ROYAL COLLEGE OF SURGEONS OF ENGLAND	102
CORRESPONDENCE: More Errata	102
PASSIM	103–104
NOTICE	104
TWO CASES OF HERNIA: Clinical Lecture by Mr. Lucas	104–109
NURSING NEWS	109
FROM THE GAZETTE'S SPECIAL PATHOLOGIST	109
GUY'S HOSPITAL OFFICERS' AND SERVANTS' ANNUAL DINNER	110
SPORT: Football—Rugby: Guy's v. St. Mary's; Guy's v. Lennox. Association: Guy's v. Old Cranleighans; Guy's 1st XI. v. Old Brightonians. United Hospitals Hare and Hounds	110–112
APPOINTMENTS	112

Calendar of Coming Events.

Mar., 1899.

Sat. 4.—1.15, Clinical lecture by Dr. Taylor.
Messrs. Golding-Bird and Dunn's take-in; Drs., E. Cohen and T. E. Holmes; Cl., R. H. J. Swan.
G.H.R.F.C., I., Richmond, away.
G.H.A.F.C., I., Felstead School, away.
G.H.P.P.S., "Parasiticism," by A. H. Davies.

Mon. 6.—Exam. for Arthur Durham Dissection Prize.

Wed. 8.—1.30, Clinical lecture by Mr. Golding-Bird.
Messrs. Howse and Jacobson's take-in; Drs., E. H. Felton and F. J. Felix-Jones; Cl., T. B. Berry.
G.H.R.F.C. v. London Hospital, Final Cup Tie.
April Appointment List closed.
Application to Medical Office for Schedules for 1st and 2nd Conjoint Exams to be made.

Thurs. 9.—G.H.M.P.U., Annual General Meeting.

Sat. 11.—1.15, Clinical lecture by Dr. Taylor.
G.H.R.F.C., I., Old Merchant Taylors, away.
II., St. Thomas's Hospital, away.
G.H.A.F.C., I., Crouch End Vampires, away.
II, Old Foresters, away.

Mon. 13.—Revision Classes for L.D.S. Eng. begin.

Tues. 14.—Meeting of Dental Society at 4.30 p.m.
Anatomy Exam. for 1st & 2nd Year's prizes.

Wed. 15.—1.30, Clinical lecture by Mr. Golding-Bird.
Messrs. Davies-Colley and Symonds' take-in; Drs., T. P. Thomas and P. D. Hunter; Cl. L. E. C. Handson.
Physiology Exam. for 1st and 2nd Year's Prizes.
Dental Anatomy Exam. for 1st and 2nd Year's Prizes.

Thurs.16—G.H.M.P.U., Address by A. G. Fraser, Esq.

Fri. 17.—Last day for sending in Fees and Certificates for Camb. D.P.H.

Sat. 18.—1.15, Clinical lecture by Dr. Taylor.
G.H.A.F.C., II., City of London School, away.
G.H.P.P.S., Treasurer's Prize Essay on "The Pathology of Jaundice."

Guy's Hospital Gazette,

MARCH 4, 1899.

Carcinoma of the Stomach.

CLINICAL LECTURE BY DR. HALE WHITE.
December 17th, 1898.

GENTLEMEN,—The case I want you to think over with me to-day is that of a woman who is in Miriam ward at the present time. She is forty years old; she is a housekeeper, and she is admitted for pain in the abdomen, vomiting, and wasting. The important things to tell you are these: her present illness dates from a year ago, when she first felt tired and languid; then soon after she began to suffer from pain in the abdomen accompanied with much flatulence. Sickness is stated to have begun at the beginning of August, and has lasted pretty continuously up to the present time. It nearly always occurs after meals, and if the sickness is absent after a meal the next time she vomits she brings up a large quantity. The vomiting is generally preceded by an attack of abdominal pain. She has noticed slight streaks of blood in the vomited matter. Usually the attacks of sickness so weaken her that she is obliged to lie down for an hour or so after each. She is losing flesh rapidly. Fourteen months ago she weighed 7 stone 13 pounds; she weighs 6 stone now. She has never noticed any lump in the abdomen.

On admission, the vomit was tested for acids, and no hydrochloric acid or lactic acid were detected. No tumour can be felt; her lungs, heart, kidneys, and organs of generation appear perfectly healthy.

In order to definitely decide the question whether acids were present in the stomach she was given a test meal. The one selected was egg and milk, and about a couple of hours after the meal was syphoned up again and tested for acid, and it was found there was no hydrochloric acid present.

Now, the reason I have brought this case before you to-day is that within the last ten

days I have seen two other cases in which a diagnosis has been made of carcinoma of the stomach, and I thought if you and I considered this subject together we might perhaps learn one or two points of interest.

In the first place, it is often suggested that carcinoma of the stomach arises in an old ulcer, and there are two specimens in the museum showing this. Only one of the three cases that I have seen during the last few days gives a history of ulcer of the stomach. But in thinking over whether carcinoma in likely to follow ulcer, you have to bear in mind that ulcer is commoner in women, at the lesser curvature, and on the posterior surface, while carcinoma is commoner in men and at the pylorus. These considerations alone will make you hesitate before assigning to ulcer of the stomach any importance as a precursor of carcinoma, and I suspect that cancer does not follow ulcer oftener than we should expect when we remember that both are common. We want someone to estimate for us what are the chances that a person suffering from such a common disease as ulcer of the stomach, will also suffer from such a common disease as carcinoma of the stomach. For my own part I do not think you would find cases in which ulcer is succeeded by carcinoma any more than can be explained by the doctrine of chances. At any rate, all that can be said is that if carcinoma does succeed ulcer, it is only because carcinoma is liable to occur anywhere in diseased structures.

Then I need hardly remind you of a fact which is of importance, but is not illustrated very strikingly by any of the three cases I have in my mind—only one of them illustrates it—and that is, that carcinoma is most frequent in the pylorus, for in 70 per cent. of all cases of gastric carcinoma the growth is situated there. The reason probably is that this is the part of the stomach which is most liable to damage.

Now I come to the next point, which I think of very great importance. This woman is forty, one of my other patients is fifty-six, and another one is about sixty. In all these three people you have symptoms of dyspepsia first noticed late in life, and I know no aphorism more important in medicine than this; that if persistent dyspepsia first appears after the age of fifty, it is almost certainly due to carcinoma of the stomach. It is very important for you to bear that in mind. If you do not, seeing how common dyspepsia is, you may say to your patient, "All right, I will give you a mixture and soon put you right;" and you diet him and give him a mixture, but he does not get any better; he is dead within eighteen months, of carcinoma; you have cruelly buoyed him with false hopes, and your reputation is gone. Of course, this, like all aphorisms, has exceptions; nevertheless, it is a very useful aphorism to remember, and you ought to be very careful before you break the law that I have laid down.

In none of these three cases is any tumour to be detected. But all have been seen by several doctors, and all the doctors have agreed that each of the three patients is suffering from carcinoma of the stomach; showing that if you take all the three patients you have the collective evidence of ten or a dozen doctors, who are all alive to the fact of the importance of permanent dyspepsia in elderly people, for it has led them to a diagnosis of carcinoma of the stomach.

Another symptom to which I want to draw your attention is pain. It is present in 90 per cent. of the cases, and it is an early symptom. All the three people I have in my mind complain of pain. Many dyspeptics do not complain of pain. You can discriminate a little as regards pain. Obviously a man with carcinoma of the stomach feels two kinds of pain. He feels the pain due to carcinoma, for cancer usually causes pain wherever it occurs. But carcinoma sets up dyspepsia, and this also may cause pain which is often felt at the junction of the first and second pieces of the sternum and between the shoulder blades. I remember a second years' student who had read an article on sarcoma of sternum, and he became quite convinced, after what he had read, that he had this terrible disease because there was a pain at the top of his sternum. A little bismuth mixture soon dispersed the subjective sarcoma. I think you will find many patients with cancer of the stomach complain of these two pains, namely, a local pain in the stomach and the pain of the induced dyspepsia between the shoulders and up at the top of the sternum. From this it follows that if the patient complains a good deal of local pain, it is some evidence that he is suffering from organic disease of his stomach.

And then another thing that I think is of very great importance—it is strikingly shown in two at least of the three cases I have in my mind—is that the patient has such a repugnance to food. The other day, I said to the old man of fifty-six, "What have you been having?" He replied, "I got up yesterday and had a little toast and tea for breakfast, and then in the middle of the day I had a poached egg and some spinach." "Had not you anything else?"

"No, I had nothing else; I really cannot touch my dinner." Now, the dyspeptic, as a rule, does not refuse to touch his dinner unless there is grave organic disease, or unless he is voluntarily dieting himself. On the contrary, he may be ravenously hungry, and often eats things which are indigestible. I think you will rarely find people suffering from repugnance to food, a loathing of it, a determination to go without their dinner altogether, unless they are suffering from organic disease, and if they are elderly you will usually find this disease to be carcinoma of the stomach.

Another clinical sign, and it is very decided in two out of the three cases we have before us, is *wasting*. You see, the person with carcinoma of the stomach often wastes for three reasons. He wastes because he does not take his food, he loathes it; what he does take he does not digest; and he wastes because all persons with carcinoma, whatever part of the body is affected, waste; and as the unfortunate sufferer from carcinoma of the stomach has three reasons why he should waste, the wasting is extreme. Our patient, although she tried to take food, has lost nearly two stone within fourteen months. In this connection, one of the patients I have in my mind struck me immensely, because I was told that when this disease set in, which was only last June, he was a fine, athletic, strong man. He got out of bed while I was examining him. I saw that his legs were reduced to mere spindles. It was easy, considering that he was suffering from chronic dyspepsia, to at once diagnose carcinoma of the stomach, quite apart from his age, although no tumour or anything else of the sort could be felt, for such rapid wasting could not follow simple dyspepsia.

Then another thing which will influence your diagnosis is that whilst nausea and vomiting are very common, they are late symptoms; the reason being that they are very largely the result of the dilatation of the stomach that follows on the carcinomatous growth in the pylorus. You will notice the patient in Miriam did not complain of her vomiting until after the pain. She dated the illness from a year ago, but she only dates the vomiting from last August.

And that brings me to another consideration that will help you in making a diagnosis, and that is, Is pain relieved directly the food is ejected? It is, as a rule, with carcinoma of the stomach, and perhaps for this reason: the pylorus is the seat of the carcinoma, and the pain may be due to the attempts to force the food past the diseased pylorus. If so, when the stomach rejects the food we should expect the pain to cease.

You will notice the report says the contents of the stomach were examined for acids. I have been asked two or three times whether this is of any importance, and I think there is no doubt that the examination for free hydrochloric acid is important. There are several ways of testing for it; I always use a mixture of phloroglucin 2 and vanillin 1, in absolute alcohol 100 parts. Having this solution ready prepared you give the patient a test meal, that is to say, some simple meal that will excite the gastric secretion. A very good meal for that purpose is a roll, a glass of milk, and the white of one or two eggs, either cooked or uncooked. Some people give a little beef steak, and a roll, and a glass of milk. Then an hour and a half or two hours afterwards you can easily syphon out the contents of the stomach. Then filter them, and in an evaporating dish, mix with the filtrate a few drops of your solution all ready prepared; warm the mixture, and if hydrochloric acid is present, as it evaporates it turns a most brilliant crimson.

The interest of that test is this: if you take people not suffering from carcinoma of the stomach and give them a test meal, nearly all will show some hydrochloric acid in their stomach. If you apply a like test in the case of patients with cancer of the stomach, by far the greater number will not show any hydrochloric acid, so that it is very strong presumptive evidence if hydrochloric acid is not present that the patient is suffering from carcinoma of the stomach. Our patient did not react to the hydrochloric acid test. I have only once known a case of gastric carcinoma in which this test showed distinctly that there was hydrochloric acid in the contents of the stomach. Why persons with gastric carcinoma should so rarely have hydrochloric acid in their stomachs is not known.

The other acid we test for in the contents of the stomach is lactic acid, which is of far less importance. To do it, add to about 20 c.c. of distilled water a drop of tincture of perchloride of iron, and then 10 c.c. of a 4 per cent. solution of carbolic acid. Mix a few drops of this solution with the filtered contents of the stomach, and if lactic acid is present the mixture will turn from blue to yellow. Our patient did not show any lactic acid, but that is of little consequence, for the presence of lactic acid only means that decomposition has occurred in the contents of the stomach.

The next point is very important. I have often urged it in the wards. Poor sufferers

from carcinoma of the stomach find that they cannot eat, and so they waste rapidly and get very ill, and then they place themselves under medical treatment, and perhaps for some time they pick up a little. The reason why a man who suffers from carcinoma of the stomach picks up after you get him under treatment is obvious. You prescribe for him simple, digestible food, some bitters to aid his digestion, he never overloads his stomach, and so, for a time, he begins to mend. Over and over again patients, by careful treatment in the hospital, have put on weight, and, naturally, the patient who has been doomed as suffering from carcinoma of the stomach becomes jubilant on putting on weight, and says the diagnosis must be wrong. But you must be no party to the raising of these false hopes. After a competent doctor has carefully thought over a case, and decided that a patient is suffering from carcinoma of the stomach, it is a good rule for him to stick to his diagnosis. He is more often right than wrong when he sticks to it, for after a temporary improvement the decline begins again. So do not be tempted to shift your diagnosis if a patient first improves under your treatment.

Perhaps some of you remember that Boswell's wife brought up some blood, and that Boswell wrote to Johnson and mentioned the fact; Johnson wrote back to say he thought a little blood coming from small vessels of the stomach was not of much moment. Whether, because was such a good-natured person, he said it to cheer up Boswell, I do not know. But it is not true. As a rule vomiting of blood is of importance. I do not mean to say that everybody who vomits blood is seriously ill, but it will not do for you to take Dr. Johnson's advice and treat the symptom lightly. Only about 30 per cent. of the people with carcinoma of the stomach vomit blood, but when they do it is an important sign as pointing to a diagnosis of carcinoma of the stomach. Remember that melæna is rare. The reason is that if any blood gets through the pylorus, the patient usually digests it long before it reaches the anus, and the patients thereby live on their own blood. I remember a case of duodenal ulcer in which, during life, we could feel the blood clot under the liver as a tumour, for the patient suddenly became very blanched, as white as a piece of paper, and a soft rounded tumour appeared at the edge of the liver. She lived a few days. *Post-mortem*, no clot was found whatever, although her bowels were not opened between the appearance of the tumour and death. All the blood must have been digested and absorbed, for there was just the sort of ulcer that might have bled.

Another sign I must mention. It is rare to feel a cancerous tumour. The reason is that the pylorus is under the liver, and almost under the rectus, just at the edge of it. While it is rare to feel a tumour, there is no sign of more importance than a rigid rectus. If the right rectus is rigid and the left flaccid, it may be a most important sign as pointing to the conclusion that the patient has carcinoma of the stomach.

With regard to the diagnosis of the organ the tumour is in, I do not think that I need go over the fallacies. I believe that when considering abdominal tumours the best way to avoid error is to remember the possible mistakes. It is waste of time almost to go over all the difficulties, and I will content myself with calling your attention to the fact, that when carcinoma spreads along the great curvature, it is very difficult then to tell it from the lower edge of the liver, or from a growth in the colon, a transverse colon full of fæces, or a thickened omentum.

Yet another point which I want to mention. You have, no doubt, all read that sometimes tetany is a symptom of carcinoma of the stomach, but it is so rare that I am fortunate in being even able to quote you a case allied to it. Gowers says, "The condition designated tetany is characterized by tonic muscular spasm or contracture affecting especially the extremities, symmetrical in distribution and either paroxysmal or continuous." Tetany is so variable in degree, and is due to so many causes, that it is quite likely that many conditions which ought to be separated are described under the one name. The patient I am about to describe did not show typical tetany, but I take it his condition is allied to it, for his muscles were thrown into a series of rapid contractions.

Dr. Slater was kind enough to write out for me what he saw in a patient whom I saw later with him. The man undoubtedly has carcinoma of the stomach. And Dr. Slater says that for several days previous to the attack he had been suffering from constipation and palpitation of the heart. The palpitation was due to a distended stomach. "He first felt a muscular twitch on Friday morning, and he was not entirely free from it till the following Tuesday. During this time there were intervals of comparative freedom from pain. When I saw him his appearance reminded me of a man shivering with cold in the lower extremities. The muscles in which shivering was most marked were

those of the thigh and calf, those of the calf most, those of the back of the thigh rather less. He complained of palpitation of the stomach coming on occasionally, so that the abdominal muscles may also have been affected. In the muscles of the inner side of the forearm there was a slight tremor, and it was occasionally well marked in the muscles of the thumb, and over the first and second carpal joints. He found he could stop this abdominal tremor by crossing his arms over the abdomen and flexing his thighs, thus bringing pressure to bear on the stomach and controlling the movements which he said he could feel. At night the tremor was at its height, and was so great that the bed shook with it, and after repeating the above method of soothing his muscles, he would lie down a few minutes and sleep, and he would wake with a start and with a great sense of fear, to find the muscles quivering again. Under opium the tremor left him last Tuesday morning, and for a month he has been free from any quivering of the muscles."

The cause of tetany in carcinoma of the stomach is unknown. It has been suggested that it is due to absorption of products of decomposition from the stomach, decomposition going on because of pyloric obstruction. This case shows that that view will have to be reconsidered. I cannot myself see what can have been the cause of these tremors if a man could stop them by merely pressing on the stomach, as he said he could.

The next point of practical importance that is very often asked in connection with carcinoma of the stomach is, whether there is any evidence of the existence of a localized fibroid tumour of the stomach? As far as I know, there is not; although I have met the following conditions:— The patient may have a fibroid puckering from a healed ulcer, and this may be mistaken for carcinoma; or a man may swallow an acid, and it is well known that corrosive effects take place near the pylorus more than in any other part of the stomach, and so you can get pyloric thickening which has been mistaken for cancer. I have also seen a gall-bladder full of gall-stones cause a good deal of thickening and matting of the pylorus because it was adherent to it. But as far as adults are concerned, these are the only ways, I believe, in which the pylorus can become thickened from any other cause than the presence of malignant tumour, and if you, in an adult, diagnose that there is obstruction at the pylorus, you have in effect almost said the man is suffering from carcinoma of it, because the other three conditions I have given you are so rare.

With regard, however, to children, there is undoubtedly such a thing as a congenital hypertrophy of the pylorus. We had a case at Guy's some years ago which was shown by Dr. Pitt at the Pathological Society, but this congenital tumour, as far as we know, causes death before adult life.

Fibroid tumours naturally leads me on to the subject of cirrhosis of the stomach. Fibroid changes not due to carcinoma or any of the conditions I have named are said to take place over the whole area of the stomach, forming considerable thickening. Well, all I can say is, I have never seen such a case, and that out of fifty cases examined microscopically by Dr. Perry and Dr. Shaw, none such were found, and many of them that looked at first sight as if they were cirrhosis of the stomach turned out not to be when the secondary enlarged glands were examined, for there you could find carcinomatous cells. The fact is that a malignant tumour of the stomach may be so scirrhous that even when many sections are examined you see nothing but fibrous tissue, but when you look at the glands you will find that it is malignant; and further, these scirrhous cancers may invade the whole stomach, forming an india-rubber bottle stomach.

It is true there is an article on Cirrhosis of the Stomach, in Clifford Allbutt's System, but the writer admits that cirrhosis of the stomach is almost the rarest stomach affection, and that only two dozen supposed cases are known; that the particulars given do not allow us to draw trustworthy influences from many of them; that the microscopic evidence upon which the earlier writers relied was imperfect, and that cancerous infiltration of the walls of the stomach may so simulate simple cirrhosis of that organ as to be indistinguishable from it save by a most careful and searching microscopic examination. So if there is such a disease as cirrhosis of the stomach, it must be excessively rare and a mere pathological curiosity, and you never ought to deny that the case is cancer until all the lymph glands in the neighbourhood have been carefully examined for secondary deposits.

I had hoped to-day to be able to discuss with you what surgery could do for the relief of gastric carcinoma, because we were going to try to relieve our patient, but unfortunately it has become necessary to operate upon her for a strangulated hernia, so we have postponed any larger operation, and therefore I had better postpone what I have to say about the question.

After lecture I want you to look at this very rare specimen. It is the brain of a woman who died of typhoid fever; besides this she had hemiplegia, which is a known accompaniment of typhoid fever, and is nearly always embolic. In typhoid fever some ante-mortem clot may be formed in the left side of the heart, and it is thence carried to the middle cerebral artery and hemiplegia ensues. When, *post-mortem*, in this case I began to look at the vessels, there happened to be a large clot at the orifice of the middle cerebral artery on the patient's right side, and I thought this must be ante-mortem, although it did not look like it, and that unfortunately in taking out the brain the greater part of the clot had been cut away. However, the piece of clot turned out to be post-mortem, and we found this large hæmorrhage in the internal capsule that caused the condition. The best account of this condition that I know is a paper in the Clinical Society's Transactions, by Dr. Hawkins, and I believe he only mentions one case of typhoid accompanied by hemiplegia in which the hemiplegia was due to cerebral hæmorrhage; all the other cases were embolic.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Pye-Smith.

Mary	26.	Chorea.
	28.	Eclampsia, probably specific in origin.
	31.	Mitral stenosis and regurgitation (emboli).
	32.	Mitral stenosis and regurgitation. Aortic stenosis.
	37.	Bright's disease.
Philip	25.	Acute rheumatism.
	31.	Tabes.
	34.	Uræmia. Cheyne-Stokes' breathing.
	35.	Acute rheumatism.
	37.	Carcinoma of pylorus. Phthisis at left apex.
	38.	Typhoid.

Cases under Dr. Hale White.

Philip	1.	Mixed nephritis.
	2.	Chronic tubal nephritis.
	4.	Hæmoptysis.
	7.	Typhoid.
	9.	Cirrhosis. Chronic interstitial nephritis. Glycosuria.
	10.	Appendicitis. Abscess between bladder and rectum. Operation.
Philip	11.	Headache. Probably plumbism.
	12.	Left pleuritic effusion. Probably growth.
	14.	Sub-acute tubal nephritis.
	15.	Chorea.
	17.	? Plumbism. ? Growth. Cystitis.
Mary	14.	Cystitis. Enlarged kidney. ? Tubercular.
	16.	Gastric ulcer.
	17.	Appendicitis.
	18.	Hemiplegia.
	19.	Peripheral neuritis. Enlarged liver.
	21.	Carcinoma of liver and pylorus.
	23.	Acute rheumatism.
Cot	53, 54.	Diphtheria. Tracheotomy.

Cases under Dr. Pitt.

Mary	3.	? Fatty degeneration of heart.
	4.	Raynaud's disease.
	6.	Bright's disease. Uræmia. Fits.
	9.	Acute pneumonia.
	10.	Rheumatism. Mitral disease.
Cot	52.	Cervical caries.
Stephen	21.	? Growth of stomach.
	23.	Perihepatitis.
	29.	? Gummata around attachments of diaphragm.
	31.	Cerebral syphilis.
	34.	Aortic disease.
	37.	Locomotor ataxy.
	38.	? Adherent pericardium.
	39.	? Pontine tumour.
	40.	Pericarditis.

"Clinical."

John	1.	? Cirrhotic liver. Æt. 7.
	3.	Appendicular abscess. Operation.
	4.	Empyema.
	5.	Appendicular abscess. Operation.
	6.	? Hydatid of liver.
	7.	Empyema. Albuminuria. Diabetes.
	8.	Enterica.
	10.	Aortic aneurysm.
	13.	Enterica.
	15.	Fibroid lung. Pleurisy.
Miriam	18.	Enterica.
	19.	Chronic tubal nephritis.
	22.	Enterica.
	23.	Aortic aneurysm.
	24.	? Tubercular peritonitis.
	25.	Old injury to head. Headache.
	26.	Pleuritic effusion.
	29.	Growth of transverse colon. Multiple growths in peritoneum. Right inguinal colotomy.
	31.	Mitral stenosis and regurgitation.
	36.	Diphtheria. Tracheotomy.

In the Surgical Wards.

Cases under Mr. Howse.

Naaman	2.	Hammer toes. Amputated.
	7.	Stricture and chronic prostatitis.
	13.	Phimosis. ? caused by malignant disease of penis.
	20.	Tuberculous hip.
Charity	16.	Rectal adeno-fibroma.
	17.	Tuberculous hip with abscess.
	20.	Æt. 30. Carcinoma mammæ. Excised.
Cot D.		Æt. 3. Tuberculous testis.

Cases under Mr. Davies-Colley.

Luke	4.	Strangulated inguinal hernia. Radical cure previously after strangulation.
	5.	Æt. 54. Tuberculous knee. Excised.
	6.	Recurrent cutaneous melanotic sarcoma. Primary growth first noticed 29 years ago.
	7.	Paraphimosis.
	7.	Stricture and extravasation.
	10.	Deformity and fixation of ankle after fracture through malleoli.
	12.	Hernia testis. Gummatous. Castration.
Lydia	2.	Tuberculous caries of ribs and lower jaw
	3.	Fibrous stricture of rectum.
	5.	Crushed leg. Amputation through knee (Gritti's).
	17.	Epistaxis.
	17.	Mammary abscess. Incised.
	18.	Suppurative periphlebitis after influenza.
Cornelius	1, 7.	Bullet wounds in hand.

Cases under Mr. Lucas.

Job	5.	Spastic torticollis.
	7.	Mastoid abscess. Antrectomy.
	16.	Stricture.
	17.	Stricture with cystitis.
	19.	Old dislocated elbow.
	21.	Epithelioma of floor of mouth.
	22.	Malignant disease of pharynx and larynx Tracheotomy.
	25.	Axillary abscess. Incised.
Lydia	12.	Recurrent carcinoma mammæ. Oöphorectomy.
	14.	Epulis. Excised.
Charity	2.	Strangulated femoral hernia. Kelotomy. Death.
	21.	Mastoid abscess. Antrectomy.
Astley Cooper	6.	Fractured base. Death from intra-dural hæmorrhage.
	8, 24.	Fractured femur.

Cases under Mr. Golding-Bird.

Lazarus	4.	Tuberculous knee.
	16.	Epistaxis.
	20.	Hallux rigidus.
Martha	16.	Recurrent carcinoma recti after Kraske's excision. Colotomy.
Cot D.		Nævi.

Cases under Mr. Jacobson.

Naaman	20.	Rectal hæmorrhage. ? Rectal polypus. ? Ulcerative colitis.
Victoria	6.	Ankylosed knee with flexion.
Cot.		Necrosis of clavicle. Sequestrotomy.
	15. and Steph. P. R.	Tuberculous peritonitis (ascitic). Laparotomy.

Cases under Mr. Symonds.

Job	10.	Æt. 47. Endosteal sarcoma of clavicle. Resection.
Martha	14.	Tuberculous abscess in hip.
	13.	Dentigerous cyst. Scraped out.

Cases under Mr. Lane.

Job	12.	Acute appendicular abscess. Incised.
Victoria	7.	Recurrent appendicitis. Appendicectomy.
	6.	Fractured first rib.

Cases under Mr. Dunn.

Lazarus	1.	? Anal ulcer.
	3.	Appendicular abscess. Incised.
Martha	13.	Branchial cleft persisting. Excised.
Cot C.		Spina bifida (meningocele). Tapped and injected with Morton's fluid.

Case for Diagnosis.

J. W., æt. 49, a sailor. Admitted on February 1st, 1899, for fits. Family history good.

Patient was always a healthy man up to the summer of 1897. At this time he did not feel quite himself, and he was noticed to do silly and unusual things. He had no fits, and soon recovered. It was not until September, 1898, that he next showed signs of ill-health. He got up early one morning and stood in the room with his hand to his head. His wife, thinking there was something wrong with him, questioned him, but received no reply. She then got him back to bed, and as soon as she had done this his left arm began to shake and he soon seemed to be in general convulsions. These kept on till about three in the afternoon; he then became quiet, but did not fully regain consciousness until two days later. He gradually recovered, and returned to his work in about five weeks. During this attack he did not speak for about thirty-six hours, and then only incoherently at first.

On December 3rd he was found in a fit in his ship. The fit was similar to the ones for which he was admitted. When his wife saw him he knew her, but could not speak to her. He knew exactly what he wanted, but was not able to ask for it. It was noticed that he had loss of power in the right arm. He was then brought up to the hospital. It was found that he

had weakness of his right arm and leg. He could understand what was said to him, but he used wrong words when he spoke himself. These symptoms cleared up somewhat, but he again became worse, and was aphasic for twenty-four hours. On the 6th his speech and intelligence were practically normal; he became very jovial, and was discharged in about ten days. From this time up to present attack patient has been fairly well. He has troubled about his work a good deal, and his wife says his memory has failed him somewhat.

He has always been a very temperate and quiet man, never had any fits when young, and there is no history of any kidney trouble.

The present condition came on suddenly about 3.30 p.m. in the afternoon of the day of admission, while he was at his work. He was brought at once to the hospital.

Condition on admission (4 p.m.)—Temperature 100·4°. Patient was having fits in quick succession. He was unconscious, passed his motions under him, and had incontinence of urine. He vomited two or three times. After he had been in a few minutes he came round sufficiently to swallow 30 grains of Pot. Brom., but he soon returned to his original condition.

The fits varied somewhat in intensity, duration and order in which they spread. The following is a description of the majority of them:—They started by twitchings of the muscles of the right side of the face, the head being drawn over to the right, and conjugate deviation of the eyes in the same direction. Next the arm muscles of that side were affected, the fingers, wrist and elbow being flexed. The leg and then the right half of the abdomen became affected last. The fit would last about 30–40 seconds.

Some of the fits started in the right arm and then spread to face and head, and leg last. Some started on the left side, and a few were on this only. Others were very severe and the whole body was involved, the patient almost going into the position of opisthotonos.

On admission the fits were practically continuous, but after twelve hours they became less frequent and less severe. Patient was a good colour, but he soon got an accumulation of mucus in his chest, and became quite cyanosed. Right knee-jerk absent, left present. The conjunctival reflexes varied somewhat; sometimes both were absent, at others both present, and at others, right absent and left present. Pupils equal, and did not react to light. No optic neuritis.

About 9 p.m. patient was bled, 12 ozs. being lost; this had no effect. At 11 p.m. chloroform was administered; this likewise had no effect. He was then given Chloral and Belladonna per rectum. This was followed at intervals by Chloral and Pot. Brom. Patient fed per rectum.

February 1st. Fits not so frequent or so vigorous. Since admission, temperature has been taken hourly in each axilla; that in the right was found to be about one degree above that in the left. The highest reached was 103°. Urine drawn off and found normal.

3rd. Fits very slight. Patient had five during the night. Patient cannot move the right arm and leg, although muscles of latter do not seem to have lost their tone completely. He took milk by the mouth fairly well in the evening. Temperature at night 102°.

4th. Patient about the same until 10 p.m., when he suddenly became much worse. Pulse 160, very weak; respiration 56; temperature 103·6°. On examining the lungs, normal resonance in front and behind. On auscultation, crackling râles at right base, with bronchial breathing; mucous râles at left base.

5th. Patient had about twelve fits in the night. Temperature 102°. Dulness behind on right side. Mucous râles heard at upper part of right chest behind. About 1.30 p.m. patient became very bad, and although he had strychnine and several injections of brandy, he died about 3.15 p.m.

Patient never moved his right limbs (except during the fits) the whole time he was in. T. P. B.

(*For solution of case see p. 112.*)

A Case of Acute Peripheral Neuritis.

THE following case presents so many features of interest that it is worth recording.

John B., æt. 40, was admitted into Philip under Dr. Goodhart, on July 13th, 1898, for loss of power and tingling in the arms and legs.

Abstract of Report.—He is a blacksmith by trade, has been abroad in South America for a few years, but has spent most of his life in Bermondsey. Had gonorrhœa at the age of 16, and a venereal disease, probably syphilis, ten years ago. He has suffered from gout, and has been a beer-drinker, occasionally to excess.

History of present illness.—Five days before admission he had pains in the back and legs, and a feeling of weakness, which progressed so that two days later he fell down and had to give up work. He was medically treated at home, but becoming steadily worse he was carried up to the hospital and admitted.

Condition on admission.—Temperature 97°, pulse 73, respirations 15. He is a powerfully-built, well-nourished man. His mental faculties are quite clear, and his speech unaltered. Both grips are feeble and he is unable to extend or flex his wrists against very slight pressure. He shows marked inco-ordination of his arms, and to a less extent of his legs, and is unable to stand. There is no pain on pressure of his limbs, even over exposed nerves, and tactile sensation is normal everywhere. There is no facial paralysis, tongue is not tremulous, and sight is normal though slight nystagmus is present. No optic neuritis. No superficial or deep reflexes can be obtained in legs, abdomen, or arms. The loss of power does not seem to be limited to any group of muscles. All the muscles react to Faradism and Galvanism, some sluggishly, though in the dorsal interossei the reaction is very weak. No qualitative changes to be noted, but in the case of the Abductor Indicis on both sides KCC is very

slightly better than ACC. The heart is hypertrophied, sounds are normal. Slightly impaired note under left clavicle, where a faint thrill can be felt. Urine normal. Some difficulty in passing water owing to a stricture, but no loss of control over bladder. Defæcation normal. Abdomen moves freely on deep inspiration ; is distended and flaccid. No ascites or abdominal pain. Liver somewhat enlarged. No blue line on gums. A good view of larynx cannot be obtained owing to an accumulation of mucus.

July 14th (day after admission). —On sitting patient up it was noticed that a little urine was passed under him. He was ordered Pot. Iod. gr. x. Mist. Hyd. Perchlor. to the ounce t.d.s.

16th.—Has been getting steadily worse. Is restless and complains of stabbing pains in the lumbo-sacral region and legs. His speech is slurred and stammering. Wasting and flabbiness of muscles of arms and legs distinctly noticeable. Occasionally passes water under him.

18th.—Sensation markedly impaired but nowhere absent. No pain on pressure of limbs. His voice is hoarse and he has difficulty in coughing up mucus, and râles can be heard all over chest. He uses his intercostal muscles very little, but the action of the diaphragm seems normal. He was ordered injections of Liq. Strychninæ mi. 4tis horis.

20th.—Is extremely weak and unable to move arms and legs. There is marked wasting of both deltoids. He is getting more choked with mucus and oxygen was administered during the night. Mind remains quite clear.

21st.—Diaphragm is becoming paralysed ; abdominal muscles remain unaffected. Wasting of the pectorals is noticeable. Sensation impaired, but not lost anywhere. His breathing got gradually worse, and he died at 4 p.m.

At the autopsy, the heart was enlarged and the liver fatty. Brain and cord and their coverings normal. Microscopically the cord showed no changes. A portion of the anterior tibial nerve was examined and showed extensive degenerative and inflammatory changes.

Clinically it was by no means easy to make a diagnosis which would satisfactorily account for all the symptoms. The ataxia and the absence of much pain and tenderness of the nerves on pressure being the chief difficulties. On the day after admission Dr. Goodhart was inclined to consider the case as one in which a general neuritis existed as part of a nervous disturbance occurring in the early stage of locomotor ataxy, and he said that in such cases the evidence of neuritis would later on clear up and leave the typical symptoms of locomotor. As the case progressed, however, he said that such a view was not tenable, and he was rather inclined to explain the symptoms by a tumour compressing the cord high up, the impaired note and slight thrill under the left clavicle being perhaps produced by it. He quoted a somewhat similar case, in which laminectomy revealed the presence of an hydatid cyst pressing on the cord. Still it was difficult to explain the ataxy by this diagnosis. The ataxy, being so marked and early a symptom in the case, could not be accounted for by muscular weakness, as it was out of all proportion to it. *Acute diffuse myelitis* was negatived by the absence of sensory symptoms, and the fact that the arms and legs were attacked early and simultaneously rendered it unlikely.

Acute anterior poliomyelitis, would account for everything but the ataxy, though the disease is generally associated with pyrexia, and is certainly rare in adults.

Landry's paralysis, or acute ascending paralysis, is by some looked on as a multiple neuritis. According to Gowers ("Diseases of the Nervous System"), it may affect the arms in an irregular manner, though it usually attacks the legs and spreads upwards. In this disease, however, the muscles neither waste nor show electrical changes, and in this case there was marked wasting of most of the muscles, which, occurring so rapidly must have been due to some trophic changes. Moreover, in some instances the reaction of the muscles to electrical stimuli was sluggish, and in one instance ACC and KCC were almost equal. The sensory symptoms in this disease are variable, though the inco-ordination which was so marked in the present case is not described as a prominent feature.

Peripheral neuritis was suggested. Against it was the fact that the sensory symptoms, especially pain, were absent, and the probable cause of such a neuritis being alcohol, pain is generally a marked symptom in such cases. An acute multiple neuritis, generally associated with pyrexia, may come on apparently after exposure to cold, or without any obvious exciting cause, and the symptoms may either exactly simulate Landry's paralysis, or, as in the present case, attack the arms and legs first, and produce paralysis and wasting of many muscles. Such was the nature of this case, although there was no pyrexia, and ataxy to such an extent is unusual.

One noticeable feature of the case was the way the man's mind remained perfectly clear to within a few minutes of his death. It is generally said that the carbon dioxide which accumulates in the blood of patients dying of a slow suffocation, produces a narcotic effect, and thus robs death of most of its suffering. Such is apparently the case with the majority of people whose lungs get gradually filled with mucus, from increasing inability to cough it up. In this case although the suffocating process was very gradual and most distressing to watch, yet the man was painfully conscious of it, and seemed in no way anæsthetised by the excess of carbon-dioxide which he had in his blood. Can it be that the unconsciousness which precedes death is due to something else than the imperfect aeration of the blood ?

A. J. C.

Papers by Guy's Men.

Micro-Organisms of the Mouth. By Kenneth W. Goadby, L.D.S. Eng.—*The British Dental Journal*, for January.

On the Value of the Treatment of Diphtheria by Antitoxin. By E. W. Goodall, M.D. Lond.—*British Medical Journal*, 28th January.

A Case of Cæsarean Section.

Mary B., æt. 31, was admitted into Queen ward on January 25th, 1899, for Cæsarean section. She was a primipara, and had been quite regular up to the beginning of April, 1898.

She was seen at 6 p.m. by Mr. Targett, on January 25th. She was then in labour, but the os, though soft, only admitted the tip of the forefinger. The pains were not strong. Vertex presentation, with the back in front, was diagnosed. The right hip was firmly ankylosed at about a right angle, as the result of old hip-disease.

Measurement of the pelvis—

Interspinous (outside)	...	9 inches.	
Intercostal	...	10	"
Ext. Conjugate	...	6¾	"
Diag. Conjugate	...	3¾	" (less if anything.)

Sacrum somewhat curved but not depressed; posterior iliac spines not specially prominent; lateral walls of pelvis very easily felt on examination. She was in good condition; pulse 96. Movements of child very active.

At 11 p.m., Dr. Galabin saw patient and decided upon Cæsarean section. A.C.E. was given, the vagina being swabbed out with lysol and the abdomen thoroughly cleansed. An incision seven inches long, with the umbilicus nearly bisecting the incision, was made through the parietes. This exposed the left appendages of the uterus owing to the excess of right tension of the uterus.

The uterus was rotated back, and the uterine incision commenced inside a Hodge's pessary to control hæmorrhage. The incision was prolonged upwards and downwards, being about six inches long. The child was quickly extracted, the cord being clamped, and the placenta, which had its attachment in the posterior surface of the uterus, was peeled off.

The uterus was then drawn out of the abdominal cavity, and the vessels in the broad ligament controlled by manual pressure. The uterus did not contract well and there was smart bleeding. The uterine cavity was plugged with gauze, and the sutures were then inserted. Silk was used, and they were inserted in a deep layer, each stitch being about half an inch apart. The closure was finished by a few superficial sutures, taking up peritoneum only.

To sterilize the patient about half an inch of the Fallopian tube was removed on each side. The abdominal wound was then closed with salmon gut sutures.

The subsequent progress of the case was very satisfactory. The temperature for the first week showed an elevation of about a degree at night, but after that fell to normal. There was not much pain and restlessness, so that no morphia was given. Vomiting and flatulence gave some trouble, but were relieved by rectal feeding, cajuput oil and turpentine enemata. After the fifth day, in which the bowels acted freely, the patient's condition became much better.

At the present time, February 13th, she is quite convalescent, and is suckling the child.

I have to thank Mr. Targett for kindly allowing me to make use of his notes in reporting this case.

V. E. COLLINS.

Royal College of Surgeons of England.

Syllabus of three lectures on "Joints of Mammals contrasted with those of man," to be delivered in the theatre of the college, on Monday, Wednesday, and Friday, March 6th, 8th, and 10th. at 5 o'clock each day, by Professor Frederick Gymer Parsons.

Lecture I.—Monday, March 6th.

The Temporo-maxillary Joint.—Its arrangement and mechanism in Man and the various mammalian orders.—Four kinds of movement.—Presence and absence of the meniscus.—The articulations of the Clavicle (sterno-clavicular, coraco-clavicular, and acromio-clavicular).

The Shoulder Joint. — Morphology of the coraco-humeral and gleno-humeral ligaments.

Lecture II.—Wednesday, March 8th.

The Elbow Joint.—Position of bones and varieties of movement in different animals.—Points of attachment of the lateral ligaments.—The presence and absence of an orbicular ligament.—The Wrist Joint.—The presence of a septum.—Articulations of the ulna in a generalised wrist joint.—Thickenings in the palmar ligament.—Morphology of the triangular fibro-cartilage.

The Hip Joint.—Thickenings of the capsule—extra-capsular connections of the ligamentum teres.

Lecture III.—Friday, March 10th.

The Knee Joint.—Appearance and twisting of lateral ligaments.—Crucial ligaments.—Separation of joint into three cavities.—Modifications of semilunar cartilages in various mammalian orders.—Superior Tibio-fibular Joint. Its use in Marsupials.—Absence of Patella in Marsupials. —Possible explanation.

The Ankle Joint.—Its ligaments in generalised Mammals.—Special arrangements for strength in Ungulates.—Interarticular fibro-cartilage in Marsupials.

EDWARD TRIMMER, Secretary.

Correspondence.

To the Editor of Guy's Hospital Gazette.

More Errata.

Dear Sir,—May I be permitted to point out the following *errata* occurring in my paper in your last issue?

Page.					
83,	line 7,	for "historical"	*read*	"histological."
84	" 51 "	"of them"	"	"of the brain."
86	" 39 "	"erythomelagia"	"	"erythromelalgia."
88	" 35 "	"somewhat"	"	"somehow."

I am, yours faithfully,

G. NORMAN MEACHEN.

Guy's Hospital, February 20th, 1899.

Passim.

On last Tuesday week Guy's held their own in the Rugby Cup ties by defeating St. Mary's Hospital by 1 goal to nil. The game was rather disappointing and an anxious one throughout, as Mary's had a very strong team and our forwards were not playing their best; also the play was tricky and by no means an example of a classic game. The final tie is on Wednesday next, at Richmond, when we meet London.

The Association 2nd XI. have successfuly met St. Bartholomew's Hospital in the Junior Inter-Hospital Competition, winning a good game by 3 goals to 2. The 1st XI. played their cup tie yesterday with St. Bartholomew's and lost by 4 goals to 2. They were playing with a weak team, as according to all accounts most of the eleven are either dead or dying, at any rate, indisposed.

We are not given to crowing over performances, especially as our play in recent matches has not always been up to the best form of the team. But it is most amusing to note what a decorous silence the journals of some of the sister hospitals keep upon the subject of recent cup ties. Either the publications must be very behind hand with the news, or grief must be too great for words.

We have to congratulate the Hospital team on winning the United Hospital ten mile race. F. E. Fremantle came in first, and R. S. Roper, third. The meeting was very satisfactory as St. Mary's and St. Thomas's both sent teams to contest the cup. This is the eighth year in succession that Guy's have won, and as the cup is one of the most handsome trophies, there is some talk of raising the necessary £25 to buy and keep it. It would certainly be an ornament to the Smoking Room, and it is to be hoped this idea will be realized.

The members of the Staff are to be sincerely pitied for the latest indignity to which they have been subjected. There hangs in the College reading-room a composite photograph group labelled Guy's Hospital Staff, 1898 (*sic*), representing all our physicians and surgeons standing at various levels in the air, in a palatial room with a nearly vertical floor. It has been aptly called the "Fashion Plate" by the irreverent, and we hope this ghastly failure will soon be put out of sight and the photographer prosecuted for libel. The Staff were wise to delay exhibiting the thing till the definite decease of the *Guyoscope*, or they would have had cause to rue their temerity.

The Annual Hospital Officers' and Servants' Dinner was held at the Bridge House Hotel on Tuesday last, and was most successful. Mr. Williams was in the chair, and Mr. Bonsor, Mr. Cohen, and others were present, including ourselves. The speeches were all above the average, and Mr. Bonsor's good humoured gibe about Mr. Pelling with his handful of workmen always busy carting round a bag of sand and a brick or two produced great merriment, for the truth of the jest was very apparent to those who live at the hospital and watch the slow progress of the universal repairs and improvements.

Apropos, there have been some happy men in Cornelius during the last week, and we could have wished to join them in their playful work. We can conceive no greater pleasure in the whole world than to light-heartedly smash every bit of wood-work in the ward, and then knock the floor into the cellars with a heavy bit of wood. No wonder Mr. Pelling and his merry men looked cheerful at the dinner. We wish we had their job, that is, in the pulling down stage; bricklaying makes your back ache.

We hope Dr. Savage will forgive us repeating the following story concerning him, but it is too good to be lost:—Dr. Savage was asked to see a patient in Philip last week, and after having examined him, was, as usual, accompanied to the door by the House-Physician. In a bed opposite there lay an old gentleman, an expert in matters alcoholic. After Dr. Savage's departure he remarked to Sister, "Who was that old gentleman with the silk 'at who has been talking to No. 41, for no end of time, and gettin' him to blow out matches and such-like games? Dr. East was the only one as spotted as 'ow he was drunk, and 'e took him out of the ward."

The first smoking concert of the year is to be held on Saturday the 18th inst., under the management of Mr. Starling. It is hoped that all who sing or play will give their names to the above-named gentleman, and help to make the evening the usual success. Above all things new blood is wanted for a hearty representative concert.

In the February number of the *Journal of Tropical Medicine* there is a paper by Messrs. Howard and Pakes upon "The Examination of Blood Films, with special reference to work on Malaria." As far as we know this is the most complete article on the subject there is, and ought to prove invaluable, as hitherto most methods published in books have been unreliable and unsatisfactory in many cases. We hope to be able to publish the paper *in extenso* in our next issue.

The Clinical Research Association has issued a circular to all veterinary surgeons, important dairymen, and others, stating that the Association is prepared to examine specimens of milk for tubercle bacilli. This will be of interest to a large number of medical men, especially Medical Officers of Health, and we give below an extract from the circular of directions for sending samples :—

"Place at least half a pint of the milk in a perfectly clean bottle which has just been thoroughly rinsed out with boiling water and allowed to cool. Cork the bottle carefully and transmit by parcel post or by rail, well-packed in a tin or wooden box, surrounded by a tight packing of absorbent material. The Association will send specially cleansed bottles and postal packages upon application.

"Each sample should have a label attached to it bearing the sender's name and some distinctive mark indicating its source for the purposes of identification. The label should also state—

1. Whether the sample is one of "mixed" milk, or has been drawn from one cow.
2. Whether the sample has been taken after the milk has been shaken, or whether it is the deposit taken after the milk has been allowed to stand some time.

"The report will state—

a. Whether tubercle bacilli are or are not found.

b. Whether the examination reveals the existence of any inflammation of the udder or not."

Notice.

Medical Department of the Navy,
Admiralty,
Northumberland Avenue, W.C
6th February, 1899.

An Examination of Candidates for entry into the Royal Navy Medical Service will be held on the 8th May next and following days at Examination Hall, Thames Embankment.

The number of Commissions to be competed for will be announced later on.

The forms to be filled up by Candidates will be supplied on application to this Department.

H. F. NORBURY, Medical Director General.

Two Cases of Hernia.

CLINICAL LECTURE By Mr. LUCAS.

January 23rd, 1899.

Gentlemen,—I have brought to-day two reports illustrating a well-worn and prolific subject for clinical lectures—two cases of Hernia.

One of these is a case in which a radical cure for femoral hernia was performed, the other is a case of strangulated femoral hernia. Both these cases occurred in women, femoral hernia being especially the hernia of females. There are so many different forms of hernia, and you may meet with such a variety of differences in the sac and in the contents of the hernia, that with a very large experience in operating you will find no two cases quite alike. In the first of these which I operated upon only last week for a radical cure, I came upon a condition which is very apt to deceive the young operator. The septum crurale contained so large an amount of fat lying immediately beneath the sheath of the femoral vessels, that it closely resembled the appearance of an omental hernia included within the sac.

There is an old remark, made by some French surgeon, I believe, that in operating for femoral hernia, when you are quite certain you have reached the sac, carefully dissect on and you will probably find the sac lies deeper. That is what occurred when I was operating last week in this case. We came down upon a swelling which had a glistening surface, and was movable on its attached pedicle, and it closely resembled the appearance of a large piece of omentum showing through the thin sac. When we opened this layer of fascia, which was really the crural sheath, we had to dissect through half an inch of fat before we reached the empty sac, which was lying collapsed and thickened within this fatty layer.

This woman is thirty-five years of age, and a dressmaker, and she is admitted for a swelling in her right groin. There is an interesting remark as regards the family history—that her mother suffered from umbilical hernia. With the exception of that we have nothing in the family history bearing upon the condition of hernia. It is well known that the tendency to hernia is to a certain extent hereditary. A hereditary weakness of the abdominal walls may be one of the conditions leading to hernia in an individual. It will be noted that the mother's was umbilical hernia, whereas the patient's is femoral hernia; so that except as a general condition of weakened abdominal walls

one does not see that there can be any hereditary connection between the two. It more frequently happens that you get a history of heredity in association with inguinal hernia depending on a failure to close the vaginal process of peritoneum.

Her history with regard to this hernia is, that about Easter last she "noticed a small swelling in her right groin, which ached when she felt tired. It used almost to disappear at times, but after hard work, standing, and walking, it would reappear." That is a very important thing in relation to the diagnosis in these cases. If any swelling appears in a position which is one of the usual sites of hernia, and you get a history that when the patient lies down it disappears, and after hard work it reappears, that is almost sufficient evidence on which to make a diagnosis of hernia. Very few swellings disappear when the patient lies down and return when the patient is taking exercise.

I will go on reading the history. "Her occupation consists in working a large treadle mantle machine for nine hours a day, sometimes more. This swelling gradually grew larger, harder and more painful, and the pain was referred to the pit of the stomach and right thigh. Micturition was painful at times." I do not think the latter symptom has much connection with hernia, but the machine-work was probably the exciting cause of the rupture. "On Saturday last, patient felt severe pains at the pit of the stomach, and on examining the hernia found it much larger and harder. It was painful to touch, and she could not reduce it. It then became as large as a duck's egg. A hot bran poultice was applied, and it went back in ten minutes. The patient was very sick twice." It is evident that she began to get symptoms of strangulation, which she narrowly escaped. Then she came up as an out-patient, and was recommended as an in-patient for a radical cure. "She is in good health, but looks rather pale and worried. She feels a dull, aching pain in the groin. There is a small swelling in the right groin which is hardly perceptible to the eye. To the touch it is a firm body situated between the antero-superior iliac spine and the pubes. It glides easily beneath the touch, but does not disappear upon manipulation. It is about the size of a chestnut. There is no impulse on coughing, and it does not pain her to touch it. The skin over it is perfectly normal, and freely movable."

An examination of this swelling seemed to show that there was no bowel in the sac. There was no impulse on coughing, which means that air is driven into the bowel on coughing and distends the sac and superficial structures. But still there was a distinct swelling there, not of a very large size, which glided underneath the fingers. Now, the condition found was one in which there was a thick fatty layer covering over the sac. The sac itself was collapsed and empty.

Well, this patient came in for a radical cure, and we cut down upon this swelling, and when we reached what looked very like a sac indeed, with omentum showing through it, we had really only reached the layer of fascia known as the crural sheath. A femoral hernia going through the crural canal, descends through the crural ring, carrying with it the septum crurale. In our patient this septum carried a large amount of sub-peritoneal fat about half an inch thick. The hernia then descends by the side of the femoral vein, and passes out of the saphenous opening, taking with it the cribriform fascia and the superficial fascia. In cutting down, you sometimes find the cribriform fascia is membranous and looks like the crural sheath, but when you have divided that you have still the crural sheath underneath, and that is very often mistaken for the true sac which is formed by the peritoneum. If there be much fat outside the peritoneum it looks very like omentum. This was one of the thickest pieces of sub-peritoneal fat I have ever seen, and within lay a thick sac collapsed and empty. We cut away the sac, and carried the ligatured end of the sac underneath Poupart's ligament, and fixed it by a suture carried through the lower part of the external oblique tendon. The way we finished the operation was by dissecting up the pubic fascia to close the crural canal.

(Mr. Lucas proceeded to demonstrate on the black-board the steps of the operation he had performed, showing how he had dissected up the fascia over the pectineus muscle to its attachment to Gimbernat's ligament, then carried the flap outwards across the canal, and sewed it to the edge of Poupart's ligament.)

That is the operation I generally perform for femoral hernia requiring a radical cure. Watson Cheyne has recommended something more than this, namely, to cut into the pectineus muscle and turn up a portion of it, and sew it up. I do not think there is any necessity for that, or that it makes any better closure than this fascia, and the inconvenience to the patient is much less in the operation I have described.

It is not always easy for students to distinguish between inguinal and femoral hernia. I will point out to you how to distinguish one

from the other, as men of great experience have mistaken inguinal for femoral, and femoral for inguinal hernia.

(Mr. Lucas here made a drawing on the black-board showing the relative position, size, and direction of the two forms of hernia.)

Inguinal hernia is the hernia of both sexes in infancy. The other hernia of infancy is umbilical. Femoral hernia is very rare under twenty years of age. About seventeen or eighteen you occasionally meet with one, but the instances recorded under that age are rareties. Inguinal hernia is common in infancy because the testis has to descend in the male into the scrotum, and the peritoneum forming the tunica vaginalis failing to close above, allows the hernia to pass into the scrotum; in the female, a process of peritoneum known as the canal of Nuck accompanies the round ligament along the inguinal canal, and failing to close leaves a congenital sac similar to that in the male. So that if there be a child with a tumour in the region of the groin due to hernia, whether male or female, it will be inguinal hernia.

Inguinal hernia is large and elongated; femoral hernia is nearly always small and rounded. An inguinal hernia has a tendency to get large because the inguinal canal easily dilates. The hernia passes through the abdominal ring and thence into the loose scrotum in the male, or into the labium in the female. When fully developed it is a large pear-shaped swelling. A femoral hernia seldom gets very large because it has to go through the crural canal, which is a hard, firm, fibro-osseous canal, that it cannot distend readily. Inguinal hernia is directed downwards and inwards; femoral hernia upwards and outwards. Femoral hernia has at first to descend through the crural canal a little in the downward direction, then it comes forward through the saphenous opening, and next passes upwards and outwards on to Poupart's ligament. An inguinal hernia has its neck above Poupart's ligament; the other has its neck below Poupart's ligament. You see that only applies really to the neck, because as the inguinal descends it gets into the scrotum, and so gets below the level of the ligament; and the femoral as it ascends passes above the level of the ligament.

But the best test of all in deciding between the two forms of hernia is to feel for the spine of the pubes. Femoral hernia very rarely approaches the spine of the pubes, being at first half an inch or so from it, and as the hernia proceeds it gets still further away; whereas, an inguinal hernia, as it approaches the scrotum, overlaps the spine of the pubes and lies to the inner side of it.

Those are the ways, then, in which you distinguish inguinal from femoral hernia. When an inguinal hernia is not fully developed, and has not come through the external abdominal ring, it is often difficult to distinguish it from femoral hernia; and when a femoral hernia lies upon Poupart's ligament, it looks very much like an inguinal hernia. The spine of the pubes is, perhaps, the best guide of all in indicating the kind of hernia. If you find the tumour quite free from the spine of pubes, the probability is that you are dealing with femoral hernia.

I want next to draw your attention to the symptoms produced by *strangulation*. This second case is one of strangulated femoral hernia, and it also presents some features of interest apart from the strangulation. This also occurred in a woman, and I see that the ward clerk, with his usual delicacy of feeling, has refrained from enquiring as to the lady's age. She is admitted for a tumour in her left groin. She is a married woman with five children, the father and mother and brothers and sisters being all alive. "The patient first noticed a swelling in her left groin in July last, which came down in the day and went back at night." Here, you will notice, is a history very similar to that of the last case. "It was only painful when the patient walked far. It remained in this condition till three days ago, when the swelling became larger and did not go back at night. Since then the patient has constantly had pain in the region of the tumour, which at times spreads across the abdomen. For these three days the patient has passed no fæces, and has constantly vomited." You notice she got the bowel strangulated three days before admission. "She says her vomit was of a yellow colour and foul smelling. She has not vomited since she came in." She was soon operated upon.

Here is a woman who has had a rupture for some time which used to come down during the day and go back at night. There is no history of a truss having been worn to keep it up, so that she was in danger, at any time, of this hernia becoming strangulated. No life assurance office will accept proposals from people suffering from rupture, unless the proposer undertakes to wear a well-fitting truss. And if the hernia be one which cannot be reduced, or cannot be kept up by a well-fitting truss, then life assurance offices generally find it advisable to refuse the risk. In the case of this woman,

as I have said, there was great danger of the bowel coming down and getting strangulated, owing to her having neglected to wear a truss.

Now the symptoms of strangulation are only three, and if you know the symptoms of strangulation you know a good deal that will serve you well in after-life. First, you must have a *tumour* in the position of a hernia. It is essential that there should be a tumour before you can make a diagnosis of hernia, a tumour either in the position of femoral hernia, of inguinal hernia, or of umbilical hernia. There are rarer sites which you might think of in a case in which you failed to find a tumour in either of these situations. Such rarer positions are into the thyroid foramen, through the sciatic foramen, through a weak point in the abdominal wall below the umbilicus, sometimes into the vagina, or into the perineum. These are rare places for hernia to occur. Ordinary hernia generally means either inguinal, or femoral, or umbilical hernia, and whichever be in question, there must be a tumour.

If the tumour be strangulated, it will no longer give an impulse on coughing. Tumours which give an impulse on coughing are those communicating with the abdomen, containing either air or fluid. An intestinal hernia gives an impulse on coughing, provided it is not so tightly constricted at its neck that the air from the abdomen cannot be driven in to distend it.

A varicocele, consisting of large veins passing into the abdomen, of which the valves are defective, will give an impulse on coughing, because the blood from the abdominal cavity is driven by the coughing along the veins so as to distend them.

In connection with impulse on coughing, another thing to remember is psoas abscess. Psoas abscess is connected with disease of the spine. The psoas muscle, within the sheath of which the abscess lies, descends from the lumbar region beneath and to the inner side of the femoral vessels, not very far from the situation of a femoral hernia. As a psoas abscess also gives an impulse on coughing, it is one of the conditions you have to think of if you are doubtful as to a case being one of hernia.

Another thing in the groin which gives an impulse on coughing is varix of the saphenous vein. It is a rare thing, but sometimes the vein will get enlarged at the saphenous opening and not below. I have known such a case sent into the hospital as a case of hernia.

Generally in all those conditions the swelling disappears when the patient lies down. I mean in cases of varicocele, varix, psoas abscess, and hernia when not strangulated or adherent.

A strangulated hernial tumour is *devoid of impulse on coughing*. People sometimes make a diagnosis of hernia without having examined for the tumour. Students, after they hear lectures, are rather apt to go home and dream of them at night. I am afraid my own lectures are seldom dreamed of. But it used to be so in olden days when the lecturers were more eloquent and emphatic, and impressed their lectures more deeply upon the minds of the students than now—that they used to go home and dream of them at night. I can vouch for the truth of this, that a student of my time, after listening to a clinical lecture on hernia, went home, sat up late reading, then took a very indigestable supper and went to bed. He woke up in the night feeling very uncomfortable, and began to vomit, and he came to the conclusion that he was suffering from a strangulated hernia. As the vomiting increased he became more anxious, and he sent for one of the demonstrators of anatomy in the middle of the night, requesting him to bring his instruments at once as he was suffering from a strangulated hernia. The demonstrator arrived, and he said, "Which side is it; where is the tumour?" And then it suddenly occurred to the man that he had never thought it necessary for him to have a tumour in order to have a strangulated hernia. It turned out that this man only wanted a little Epsom salts, and the next morning he was all right again—it was only a bilious attack.

Now, on the other hand, it is very essential, if you be called to a person suffering from a supposed bilious attack, that you should exclude the possibility of that person having a hernia of some kind. Terrible mistakes may be made in such cases. Persons who for years may have suffered from bilious attacks may send for you when they are really suffering from something much more serious. Mistakes are made because doctors do not examine cases when first called to them, and they think these are only cases of bilious attack, and they order purgatives, when the patient is really suffering from strangulated hernia, and so valuable time is allowed to pass before the necessary operation is performed. If the case is diagnosed at once there is no reason for fear as to the result. If the tumour cannot be reduced by gentle pressure, the earlier the operation is done the better will be the result. It is where the doctor is too late in forming a diagnosis that the danger of strangulated hernia comes in.

I could tell you the case of a penurious old lady, an old maiden lady, who died of strangulated hernia without even sending for a doctor. She was subject to bilious attacks, and she used to take for these bilious attacks some family nostrum that she kept in the house. She was cautious in sending for doctors because she had not very large means, and so she rather grudged paying doctors' bills. Eventually she got a very severe bilious attack, as she thought, and she took the usual medicine, but could not get her bowels to act. The vomiting continued and she took some more of her household medicine, but with the same result. She positively remained in that condition without calling in a doctor until she died. She continued to vomit for some days, but still persisted that she was only a little bilious. At last she got up in the night and was going across to the basin with a view of vomiting again, I presume, when she fell down in a fainting fit and died. There had to be a post-mortem examination, and it was found that this poor old lady, without having called in a doctor at all, had positively died from the effect of a strangulated femoral hernia.

In cases, then, where there is a bilious attack and vomiting, and where the bowels do not act, you should, as I have been trying to impress upon you, examine at once and ascertain if there is a tumour. If you have any suspicion that the symptoms are dangerous, you must really feel in the inguinal region and determine for yourself if there is any tumour, because patients are very apt to deny the presence of a tumour, and they do so, probably, very often without knowing that there is any swelling there.

I have told you why the impulse is absent—because the constriction is so great that air cannot be driven into the bowel to distend it. Then comes the *persistent vomiting*. Our patient vomited for three days. The contents of the small intestine were thrown up, yellow, flaky, and foul-smelling. This vomiting was associated with *constipation*, but the constipation is the least important of the three symptoms. In this particular case there might have been fæces passed, as the whole circumference of the bowel was not strangulated, only one side of the bowel being caught in the ring. These are very deceptive cases, known as Richter's herniæ. You should always remember that in cases of strangulation there are usually three symptoms present; there must be (1) a *hernial tumour devoid of impulse*, (2) *persistent vomiting*, and (3) *constipation*.

I will go on reading the report of this particular case. *Condition on admission.*—"There is a swelling in the left groin, about two and a half inches in length, and one and a half in breadth. It is about half an inch from the spine of the pubes, and just below the line of Poupart's ligament. The tumour is fairly tense and gives little impulse on coughing." It is very easy to deceive yourself in these cases. The report says, "It gives little impulse on coughing." Now if you get your hand close to the lower part of the abdominal wall you may deceive yourself, because the lower wall of the abdomen gives a sort of general impulse on coughing; whereas the impulse given in a case of unstrangulated hernia should be a distending impulse—the air is blown in and it distends it in all directions. If you simply put your hand on the lower part of the abdomen you can easily deceive yourself that there is impulse on coughing. I have not the slightest doubt that this tumour had no actual impulse on coughing, no distending impulse, but a mere general impulse common to all the lower part of the abdomen.

"The tumour is not reducible. The patient complains of pain at the tumour, and the discomfort extends up into the abdomen at intervals." Generally in these cases there is pain in two situations, at the tumour, and about the umbilicus.

"*The operation.*—A.C.E. was given, and the parts which had been previously shaved were well washed. An incision was made vertically over the tumour, not quite in the middle line of the tumour, but to the inner side of it. The skin was dissected off the various layers till the sac of the hernia was reached." The operation was performed by my house-surgeon who has just gone off, Mr. Philip Turner. "The sac having been reached and opened, a director was passed under the constriction and this was divided. It was found that there was a small piece of omentum in the sac which was blood-stained, and a small portion of strangulated gut which was not the whole circumference of the gut. It is a dangerous hernia where you get only one side of the bowel caught as in this case, and not the whole circumference. Cases of this kind are called Richter's hernia, and a little fæces may be passed as the whole circumference of the bowel is not strangulated, and so the symptom of constipation is not invariably present. Well, this small piece of bowel was "of a palish-red colour." I did not think it so bad, but that it would recover. The strangulated bowel was reduced, and the piece of omentum was ligatured and cut away. The

operation was completed in the same way as that I previously described to you. The sac having been cut away, the ends of the sac were carried into the ring, and the ligatures were carried up underneath Poupart's ligament, and then the pubic fascia was dissected up and sewn over on to Poupart's ligament. Primary union of the wound took place after each operation, aseptic details being complete in both the cases mentioned.

With regard to the diagnosis of femoral hernia, there are other tumours which occur in this region. Frequently you find in this region an enlarged gland. Cases of this kind are occasionally sent into the hospital for hernia, when the patient has a little sickness associated with the swelling. I remember perfectly well a case of the kind being sent into one of the wards some years ago for strangulated hernia. On examination, however, it was found that the tumour in the groin was an enlarged gland, the immediate cause of which was a discharge from the vagina. In other cases, enlarged glands may be due to irritation at the heel, especially in children. They are harder and often more tender than hernia.

Then, you may also find a lipoma. That would not give any impulse on coughing, and by taking a lipoma in your fingers you can feel its soft lobular consistency, and so distinguish it from a hernia. An omental hernia is practically a lipoma, but it has a deep attachment unlike a lipoma of the subcutaneous fascia.

A varix of the saphenous opening I have already mentioned. It is a rare condition, but when it does occur it is not easy to distinguish from a hernia. It completely disappears when the patient lies down.

Cysts occasionally occur in this region, and you know these by their fluctuation and firmness.

Sarcomata also occasionally occur in this region in the cellular tissue. I have operated in one such case upwards of twenty times. The sarcoma kept recurring, and eventually got deeper and deeper into the muscles of the thigh and abdomen, until it became impossible to do anything more. A sarcoma occurring in the cellular tissue of this region may in its early stage be mistaken for hernia, but it never disappears on lying down, and reappears with exercise as a hernia so frequently does, but continues gradually to grow.

Having recapitulated the conditions which might be confused with a case of femoral hernia, the lecturer continued: The temperature is very seldom raised at all in strangulated hernia, but perhaps you may find it raised a degree. The temperature, as a rule, is generally about normal, even in bad cases of strangulation. In the worst cases, perhaps, the temperature will be found subnormal, where the patient goes gradually into collapse. Pain, an anxious countenance, hollow cheeks and eyes, distension of the abdomen, and evidence of peristalsis are among the signs due to the obstruction of the intestine. But, remember, the three symptoms you are ever to retain in your minds to the end of your days are (1) the presence of an irreducible hernial tumour devoid of impulse, (2) persistent vomiting, and (3) constipation.

NOTE.

We regret that owing to the late date at which the reporter sent in Dr. Newton Pitt's clinical lecture on an "Abdominal Tumour," published in our issue of February 18th, and to other delay, the proofs could not be corrected. There are, unfortunately, several errata, but the following important ones especially require correction:—

Page 70, line 26, for "hypogastric" read "right hypochondriac."

Page 71, line 36, for "malignant disease of the liver" read "renal tumour."

Page 72, line 37, for "dulness" read "resonance."

Page 72, line 39, for "never have dulness" read "are never resonant."

Page 72, line 3, for "renal" read "splenic."

Nursing News.

We regret to have to announce that Nurse Harriss, (Mary ward) left the Hospital on February 21st, but at the same time we must congratulate her on her appointment as Nurse-Superintendent to the Hospital for Women, Birmingham.

Probationer Knox, who has been with us for nearly two years, and was previously at the Hospital for Sick Children, Shadwell, for three years, has been appointed Head Nurse in Mary ward.

Nurse Jeffery has been transferred to Patience ward, and Probationer Bowen has been appointed Head Nurse in Luke. Probationer Bowen has completed two years' training.

From the Gazette's Special Pathologist.

H., Ramsgate.—No tubercle bacilli could be found in the sputum.

H. V. R., Fordingbridge.—The specimen was sent up in glycerine which spoiled it for histological purposes. But there was no naked eye evidence of malignant disease, the mammary tissue being merely fibroid.

PATHOLOGIST.

Guy's Hospital Officers' and Servants' Annual Dinner.

The Annual Dinner of the Hospital Officers and Servants took place on Tuesday, February 28th, at the Bridge House Hotel, and proved an immense success.

Mr. Williams presided, supported by the Treasurer and Mr. Cohen, as representatives of the Governors, while the Medical School contributed a guest in the person of Mr. Fagge.

Dinner was served as punctually as dinners are on these occasions, and was progressing merrily, when an alarm was raised that Victor had disappeared! Certain was it that his chair was vacant. Numerous were the suggestions offered to account for this strange incident, but soon all anxiety was allayed by his appearance, staggering under a load of "Bass," which he proceeded to distribute with his characteristic *bonhomie*. After this little interlude some steady and consistent jaw work was got through in a masterly manner, till, with loosened waistbands, we waited for the flood of eloquence to be expected at such a time and place.

The loyal toasts disposed of, we smoked and listened to Mr. Wells proposing the Hospital and School in an excellent speech. Mr. Bonsor and Mr. Fagge responded, both in great form. Mr. Fitz-Hugh warbled, Mr. Churcher recited, and then—more speeches by Mr. Croucher, proposing the visitors, and Mr. Cohen proposing the chairman and Mr. Williams replying, all interspersed with more harmony by Messrs. Brockwell, Sam Wright, Robinson, Spon, Lulham, Hartland, Cazenove and Churcher. After the speeches were all over, more music, and then "Auld Lang Syne."

Altogether, a great evening. Everybody seemed to enjoy themselves; I know I did.

Sport.

Rugby Football.

GUY'S v. ST. MARY'S.

Inter-Hospital Cup.—Semi-Final Round.

Taking all things into consideration, the result of this game on Tuesday the 21st ult., is from a Guy's point of view, to be set down as satisfactory. It may be stated at the outset that the score, a goal to nil in favour of Guy's, just about represents the superiority of the winners Certain it is that they deserved no more, indeed there were some who said that a draw would have been a more accurate representation of the respective forms. Be that as it may, what really happened was this. A high wind, was blowing almost straight up and down the ground (the upper one for some unaccountable reason was used), which, at its best, is very unprotected, entirely spoilt the game as such. It was merely a question of one side defending vigorously for the first half of the game and attacking continuously for the second, and vice versa. Guy's defence did not once break down, Mary's did once, and that time Jackson got over rather wide out; and so with O'Brien kicking a beautifully-judged goal, Guy's managed to reach the final. It is well-known that a wet day and heavy ground always has the effect of more or less levelling up the weaker team to the standard of the stronger, and the same it seems applies to a windy day, for last Tuesday week was otherwise perfect, and the ground in excellent trim. We confidently believe that had the elements been more propitious, the margin in favour of Guy's would have been considerably larger. Nevertheless the losers are to be congratulated on playing a splendid game—and quite the one that the occasion demanded; and it is to their forwards that the greatest meed of praise is due. They played a hard, honest game from beginning to end, and were never once over-run. Their half-backs, too, effectively broke up any attempts at combination that the wind left them to do, and so considerably lightened the work which the three-quarters and full-back would otherwise have had to tackle. The whole team had evidently trained well for the game, and were certainly fitter and showed more dash than did our team (*verb. sap.*).

The game being such, a detailed account is quite superfluous, Guy's defended for the first half and attacked for the second. The defence was very sound, and the play of the forwards at this stage of the game was really admirable. They wheeled the majority of the scrums, and it needed all the resources of the Mary's backs to prevent them making headway even against the wind. Once, indeed, war was carried into the enemies' country, and play reached the Mary's twenty-five line, but the burst did not last long, and half-time arrived with the score sheet still a blank.

To tell the truth, the second half of the game, except for the time that Jackson scored from a pass by Rae after a very pretty piece of play, was not quite as much in favour of Guy's as the first had been in favour of Mary's, for every now and again play was in the centre of the field, and beyond it for some minutes at a time, and at no time did Guy's look as if they were going to swamp their opponents. Whether it was the wind or something else, the passing never once reached the pitch of excellence shown in the Thomas's match, and for this, the halves were, if anyone, to blame. They never seemed able to get rid of the ball before their opponents were right up to them, and time after time they were collared with the ball. However, all's well that ends well, and it was a distinctly useful game for the team to have indulged in, showing as it did, what dogged keenness can do against what on form was an immeasurably stronger side. The Guy's team was as follows:—

Guy's.—A. C. Ransford (back); F. L. Rae, A. O'Brien, F. W. Sime, C. T. Hilton (three-quarter backs): F. D. S. Jackson, M. C. Wetherell (half-backs(; R. C. Mullins, A. Ayre-Smith, H. A. Cutler, D. H. Trail, T. P. Thomas, A. H. E. Wall, P. T. Manson (forwards).

Remarks.—Considering that he had only played one game since his accident, Ransford played splendidly. He saved in quite his old style, but his kicking was a trifle slow, and he allowed one drop which he ought to have got in, to be charged down. O'Brien and Rae showed up best of the three-quarters; Sime, until he went centre towards the end of the second half, had hardly anything to do. Hilton was very bad at fielding the ball and saving, and if he is to keep his place must learn to pass and take his passes better. Rae tackled beautifully, being always on to his opponent like the proverbial knife. O'Brien as usual kicked very well. Jackson and Wotherell were not as good as usual, and in addition had a clever pair opposed to them. To our mind they tried to make openings too often, and in consequence were frequently tackled with the ball in possession. The forwards as usual were very good, and they were seen at their best during the first half of the game. During the second, the heeling was hardly as smart as it ought to have been, and Mary's got the ball all too frequently. Mullins, Trail and Manson were perhaps the pick. On the Mary's side, as before mentioned, the forwards played a rattling game, and there was no shirking whatever. Luxmoore, Graham and Worthington showed excellent form. Of the outsides the halves did an immense amount of work, Crozier's play being very prominent. It was not Cowey's day out.

GUY'S v. LENNOX.

Owing to the Second Fifteen Cup Tie versus Wimble don being played at Honor Oak Park, this, our second game with Lennox, was played at Stamford Bridge last Saturday week.

The game was of a somewhat scrambling character, and neither side showed as good form as they generally do. Both Rae and Sime scored for Guy's, and a poor game resulted in a win for us by two goals to nil. Team:

Guy's.—A. C. Ransford (back); F. L. Rae, F. W. Sime, A. O'Brien, C. D. Pye-Smith (three-quarters); F. D. S. Jackson, T. P. Thomas (half-backs); R. C. Mullins, D. H. Trail, A. A. Smith, H. A. Cutler, P. T. Manson, A H. Wall, F. R. Featherstone, C. F. Watson (forwards).

Association Football.

GUY'S v. OLD CRANLEIGHANS.

This match was played at Honor Oak Park on Saturday, February 18th, and resulted in a win for the hospital by 4 goals to 1. The Old Boys had not a particularly strong team, and at the same time turned up one short. The ground was very heavy, thus making the game very slow. The play in the first half was very even, Guy's, however, had rather the best of the exchanges. At one time our opponents looked like scoring, putting in two very hot shots in quick succession, but nothing resulted. Our shooting was not very brilliant, several good openings being missed. Just at half-time Norton scored the first goal for us. In the second half Guy's had it quite their own way, although soon after the re-start Greenfield had to retire as he received a nasty kick. The Old Boys, except for one or two rushes, were never dangerous, but from one of these they obtained their only goal. Lacey, Langdale and Morris each obtained a goal, the latter's being a very good one. Nothing further resulted. Guy's thus won by 4–1. Lacey has improved considerably and seems to understand the game better than he did, Greenfield, too, played much better until he got hurt, but he is still very slow. Team:—

Guy's.—A. R. Thomas (goal); J. Mathews, N. P. Shepherd (backs); R. W. B. Hall, D. G. Greenfield, J. M. Brydone (halves); H. L. Dent, H. M. Langdale, E. Norton, H. K. Lacey, F. Morris (forwards).

GUY'S 1st XI. v. OLD BRIGHTONIANS.

On Saturday, February 25th, the First XI. had for their opponents at Honor Oak a strong eleven of the Old Brightonians. The ground, for the first time for many weeks, was in a playable condition, an event which ought to have augured well for a good game.

The Old Boys started playing against the sun, but with a strong wind in their favour, an advantage their heavy forwards were not slow in making the most of. Smith was early tested in the game with some long shots, but the attempts of the Guy's attacks to score in the early par of the game were weak in the extreme. Matthews, the end of about a quarter of an hour's play, let in the opposing forwards, and as a result Smith was easily beate The Guy's forwards then woke up a bit and some good, but individual attacks, were made on the Old Boys' goal, Norton and Lacey showing up well, the former putting in some fine shots, which were brilliantly saved. At this part of the game it was noticed that the home halves lagged too far behind the forwards during their short periods of attack. Weak back-play enabled the Old Boys to score their second goal, and Smith allowing a long shot from the left to slip through his hands, th Old Brightonians changed ends with the substantial lead of 3 to 0.

With the advantage of the wind during the second half the hospital were able to attack considerably more than they had done during the initial half. Norton and Morris were responsible for some fine shots, and both had hard luck in not scoring. From a capitally placed corner by Brydone, Mandy was able to screw the ball into goal. The second goal to the hospital was presented by the visitors' left half, who scored with a fine screwing shot.

With the score 3 to 2 against the hospital play became fast and consequently improved, and Hall, receiving the ball from the right, was able to make the score level with a long drive—a fine effort—the game soon ending with the score 3 goals each.

With the exception of failing to field a long shot, and so giving away a goal, Smith's display in goal was of a satisfactory nature. Shepherd, who seems to improve every match, gave a capital display at right full back, tackling man after man in brilliant style. Matthews seemed bothered by the wind during the early part of

the game and started weak, but later on improved considerably and tackled in his well-known vigorous style.

Of the halves Hall played as well as could be expected after his recent sleepless nights; Greenfield, too, played under the disadvantage of a bruised side, and worked hard; Brydone did not seem in the best of condition. Lacey at centre forward played a hard and much improved game, and with greater shooting powers might develop into a first-class player. Norton and Morris combined and shot well. Roberts did some good things occasionally, but was ill-supported by his wing man. Mandy turned out at the last moment in an untrained condition, and clad in borrowed plumes of unique fit. We were glad to see H. B. Onraët again ably filling the duties of referee after his recent success at the exams. Team:—

Guy's.—F. M. V. Smith (goal); N. P. Shepherd and J. Matthews (backs); R. W. B. Hall, D. G. Greenfield, and J. Brydone (halves); P. S. Mandy, W. O. Roberts, H. K. Lacey, L. Norton, and F. Morris (forwards).

United Hospitals Hare and Hounds.

INTER-HOSPITAL CHALLENGE CUP.

The Inter-Hospital Cross Country Cup was contested last Saturday over a 10-mile course at Chingford, and resulted in an easy victory for Guy's for the eighth year in succession. Bart.'s scratched at the last, so only Mary's, Thomas's and Guy's were represented. At the same time the Hulton Cup and a sealed handicap were decided, the former being won by F. E. Fremantle and the latter by R. S. Roper with a handicap of six minutes. Dr. H. A. Munro was judge, and Mr. S. Chester-Cox timekeeper and starter. The following were trail-layers—D. L. Morgan, F. O. Stoehr, G. T. Brassey.

Order of Arrival—	min.	secs.
F. E. Fremantle (Guy's)	64	47
A. C. Birt (Thomas's)	66	29
R. S. Roper (Guy's)	66	58
J. F. Robinson (Guy's)	68	24
P. G. Easton (Mary's)...	68	55
R. E. Brayne (Guy's)	69	19
H. Cochrane (Thomas's)	73	29

Appointments.

CIVIL.

Berry, H. Poole, M.B. Lond., M.R.C.S. Eng., has been re-appointed Medical Officer of Health to the Grantham Urban Sanitary District.

Fuller, W. A., M.R.C.S., L.R.C.P., has been appointed Senior House-Surgeon to the East Sussex and St. Leonard's Hospital, *vice* C. R. Nicholson, M.R.C.S., L.R.C.P., resigned.

Mayston, R. W., M.B. Lond., L.R.C.P. Eng., M.R.C.S., has been appointed House Physician to the Seamen's Hospital (*Dreadnought*), Greenwich.

Thomas, D. W., M.R.C.S., L.R.C.P. Lond., has been appointed Surgeon to the Union Steamship Company's ss. *Gaul*.

NAVAL AND MILITARY.

The Queen has been pleased to confer the Volunteer Officers' Decoration upon Surgeon-Major Charles Knott, of the Volunteer Battalion of the Hampshire Regiment.

Surgeon J. D. Hughes, R.N., is promoted to be Staff Surgeon, and is appointed to the *Tartar*; Surgeon Richard F. Clark, R.N., is appointed to the *Niobe*, and Surgeon J. G. Watt, R.N., to the *Pamona*.

Lieutenants Frederick S. Brereton and John C. B. Statham are promoted to be Captains.

Solution to Case for Diagnosis, see p. 99.

Patient had extensive pneumonia, the whole of the right lung and left lower lobe being affected (red hepatization).

Brain normal, as far as could be seen by the naked eye.

From this autopsy the diagnosis of the case must be G.P.I. and pneumonia.

The fact that the patient had such definite paralysis of the right side suggested that the diagnosis would be left cortical irritation due probably to softening or perhaps tumour.

Births.

GILLBARD.—On January 28th, at Falkland, Brighton Road, Sutton, Surrey, the wife of R. Gillbard, L.R.C.P. Lond., M.R.C.S., of twin sons.

McGAVIN.—On February 12th, at 14, Sheffield Gardens, W., the wife of Lawrie Hugh McGavin, M.R.C.S., L.R.C.P., of a son.

OSBORN.—On February 7th, at the Chalêt, Dover, the wife of Arthur Osborn, M.R.C.S., L.R.C.P., of a daughter.

Marriage.

FOTHERGILL—DEXTER.—On March 1st, at St. Martin's Church, Charing Cross, London, by the Rev. C. D. Fothergill, M.A., Ernest R. Fothergill, M.B., B.S., eldest son of Thomas R. Fothergill, of Tunbridge Wells and Kendal, to Fannie Plues, youngest daughter of the late George Hornsby Dexter, J.P., of Gateshead-on-Tyne.

Death.

KNIGHT.—On January 27th, at the Parsonage, Rainham, Kent, John Sladen Knight, M.D., M.R.C.P., aged 78.

Ed.—H. L. E.

Contents.

	PAGE
FOUR CASES OF HYSTERECTOMY FOR FIBROID TUMOUR: Clinical Lecture by Dr. Galabin	113–120
HOSPITAL NEWS	120–122
IN LIGHTER VEIN	122–123
GUY'S PHARMACOPŒIA: A Forecast	123–124
REVIEWS	124
CHAPEL NEWS	124
SOCIETY OF APOTHECARIES OF LONDON	124
PAPERS BY GUY'S MEN	124
PASSIM	125–126
PANCREATIC INFLAMMATION AND HÆMORRHAGE: Paper by Mr. W. T. Milton	126–133
SPORT: Football—Rugby: Guy's v. London—Inter-Hospital Challenge Cup (Final Tie); Guy's Hospital "A" v. Surbiton. Association: Guy's v. St. Bartholomew's—Inter-Hospital Challenge Cup (Semi-Final Round); Guy's 2nd v. Old Forester's 2nd; Guy's 2nd v. St. Mary's 2nd—Inter-Hospital Junior Cup	133–136
APPOINTMENTS	136

Calendar of Coming Events.

Mar., 1899.

Sat. 18.—1.15, Clinical lecture by Dr. Taylor.
Messrs. Davies-Colley and Symonds' take-in; Drs., T. P. Thomas and P. D. Hunter; Cl. L. E. C. Handson.

Sat. 18.—G.H.A.F.C., II., City of London School, away.
G.H.P.P.S., Treasurer's Prize Essay on "The Pathology of Jaundice."

Tues. 21.—Schedules for Final Conjoint Examination to be left at the Medical School Office.

Wed. 22.—1.30, Clinical lecture by Mr. Golding-Bird.
Messrs. Lucas and Lane's take-in; Drs., J. Atkins and H. B. Foster; Cl., R. Balderston.
Exams. for Junior and Senior Prizes for General Proficiency, and for the Michael Harris Prize and Sands Cox Scholarship.

Thurs. 23—Exams. for Golding-Bird Gold Medal and Scholarship begin.
G.H.M.P.U., Devotional Meeting.

Sat. 25.—Lectures cease.
Last day for applying to Registrar for Form of Entry for Final M.B London.

Tues. 28—First Conjoint Exam. begins.

Wed. 29.—Messrs. Golding-Bird and Dunn's take-in; Drs., E. Cohen and A. Fraser; Cl., W. H. M. Telling.
Second Conjoint Exam. begins.

Fri. 31.—Good Friday, Medical Office closed.

Guy's Hospital Gazette,

MARCH 18, 1899.

Four Cases of Hysterectomy for Fibroid Tumour.

CLINICAL LECTURE BY DR. GALABIN.
February 15th, 1899.

GENTLEMEN,—During the last two months we have had several cases of Hysterectomy for Fibroid Tumour of the Uterus. Therefore, I propose to take that subject for a lecture to-day.

As you know, fibroid tumour of the uterus is a disease which is not necessarily or usually fatal, and therefore in consequence of this, the question of operation is generally one not of necessity, but of expediency. It is not as in the case of ovarian tumour, in which there is no doubt at all that an operation must be done if practicable. But the most anxious question in most cases of fibroid tumour of the uterus, is, whether an operation should be recommended or not. There are some authorities nowadays who think so little of the risks of the operation, and lay so much stress on the inconvenience caused by fibroid tumour, that they advise an early operation in all cases. But the general practice is only to operate if either symptoms of danger arise, or if the patient is suffering from serious distress; and at Guy's our practice has certainly been of that nature, and, if anything, we have tended to err rather on the cautious side than on the opposite.

As regards the various symptoms or conditions which form indications for operation in cases of fibroid tumour of the uterus, probably the commonest is that of hæmorrhage. This mostly takes the form of menorrhagia, sometimes that of metrorrhagia. Sometimes after the patient has suffered a long time from menorrhagia, the character of the hæmorrhage is altered, or becomes constant or variable. This latter especially, I think, is always a serious matter, and a reason for the most careful investigation, if not for operation, as it sometimes means that the tumour is becoming complicated by cancer. It is a very rare thing for actual malignant degeneration of a fibroid tumour to occur, but it is not so very uncommon for it to be complicated by cancer starting in the mucous membrane, and invading it from thence. I have met with several cases in which cancer has been limited to the mucous membrane covering the fibroids; the reason probably being that the fibroid tumour actually did predispose to the cancer by making the mucous membrane unhealthy.

Although in general you may decide as to the real condition existing by exploring the interior of the uterus and bringing away a piece for

microscopic examination, yet I have met with cases in which one could not reach anything suspicious, and yet when the whole tumour was removed cancer was proved to be present.

As regards the indication for an operation on the ground of hæmorrhage, although it very rarely happens that the patient actually bleeds to death from a fibroid tumour, yet she is often reduced to great anæmia, and, in addition to that, the effect of the anæmia may be to predispose her to other diseases which may, perhaps, prove fatal. Therefore, where there is a condition of great anæmia, an operation may be advisable.

Then if the tumour is of such great size as to cause much inconvenience to the patient, and to threaten damage to vital organs by abdominal pressure, that again is a reason in most cases for operating, although one sometimes finds that patients with an enormous tumour prefer to endure the tumour rather than undergo the risk of an operation.

There is one important point which, I think, should be considered in these cases. Not only is there danger from local pelvic pressure, but as the result of general abdominal pressure there is a tendency to kidney degeneration. I am always accustomed, therefore, in cases of fibroid tumour of the uterus, to watch the condition of the urine, as well as the pulse-tension, and if any albumen or other sign indicating the probability of damage to the kidneys appear, I think an operation is desirable.

Not only is the excessive size of the tumour to be taken into account, but the rapidity of its growth. It is, of course, obvious that the risk of an operation is much less when the tumour is of moderate size than if you wait until a great size is reached, equal it may be to that of full-term pregnancy, by which time the tumour may have stripped up the peritoneum from the pelvis. The ordinary history of fibroid tumour of the uterus is that it goes on growing till the menopause, then ceases to grow, and in many cases shrinks. There are a few exceptions to that rule. But the tumour not only continues to grow till the menopause, but it has an important influence in postponing the date of the menopause. And you may say that a patient with a fibroid tumour of considerable size, which enlarges the cavity of the uterus and causes excessive menstruation, will probably not get the menopause until the age of fifty-five or so, instead of at the usual age of about forty-seven or forty-eight. Hence it follows that in a case of fibroid tumour of the uterus, the symptoms being equal, there is much more reason for operating between thirty and forty, than if the patient is over forty; and when the normal date of the menopause is passed, although the menopause may not yet be showing itself, say between the ages of forty-eight and fifty-five, it is only exceptionally that an operation should be advised.

Even more important than the effects of pressure on the abdomen generally are those of pressure on the pelvis. Whilst this may occur with a fibroid tumour in the body of the uterus, it is more especially seen in those partially or wholly involving the cervix. With a tumour of such a nature there is greater reason for interference while the whole growth is of a comparatively moderate size, because a tumour in such a situation is exceedingly likely to strip up the peritoneum, and in its more advanced stage it is one of the most difficult operations possible in surgery to remove it.

Among the structures which suffer from this pelvic pressure is—first, the rectum, in consequence of which you get trouble from constipation and interference with intestinal peristalsis.

But more important still is the possible effect upon the bladder and the ureters. The fibroids which most commonly cause retention of urine are those situated in the posterior wall either low down in the body or in the cervix uteri, so that they press the neck of the bladder forward against the pubes. A similar result may happen when a fibroid tumour in the anterior wall presses the bladder against the pubes. If, therefore, you have in this way retention of urine produced, and recurring for some time, catheters having to be frequently employed, it is better not to wait until cystitis has been set up by distension of the bladder, but to interfere at an early stage.

Another symptom which will often be of help in deciding the treatment, and perhaps the first to lead the patient to consent to some operative procedure, is the pain in the tumour. This may be produced by several causes. In many instances one cannot distinctly say why in one individual pain should be produced by a comparatively small tumour, while a larger tumour may be quiet painless. But there are two prominent causes of pain. One is a degeneration in the tumour generally caused by some interference with the circulation, and which may lead, in the first instance, to an aseptic necrosis, but one which may eventually become septic. It is difficult to say whence the septic material is derived; but it may be that from adjacent or adherent intestine, or from the uterine cavity either directly or along the Fallopian tubes, microbes are transmitted and lead to abscess, possibly discharging into the

uterine cavity. In one such case I found an abscess in the tumour, of which there was no suspicion before operation, discharging by two large openings into the cæcum.

The question whether there is any necrosis or septic inflammation in the fibroid tumour is often very difficult to solve. If you get pus formed and discharged per vaginam, you have proof of it. But there are cases, as for instance, two out of the four which I shall speak of to-day, in which, without any very definite evidence beforehand, necrotic degeneration about the tumour is found; and I think one symptom to be regarded as pointing to the possibility of that is considerable and persistent pain in the tumour. Therefore not only on account of the distress caused by the pain, but from its possibly indicating changes in the tumour, such a case may be properly regarded as one for operation.

Besides this necrotic change there are other inflammatory conditions that may occur, among them being peritonitis. While in ovarian tumour peritonitis is very common if the tumour has existed a considerable time, it is comparatively rare in fibroids of the uterus, although the natural course of this class of tumour is much more prolonged. The common cause of peritonitis in cases of ovarian tumour is some necrotic or degenerative change in the tumour, which sets up peritonitis over it. The same thing may happen, but much more rarely, with a fibroid tumour. Of more common occurrence is a peritonitis which is comparable to the ordinary form of pelvic peritonitis, arising from the spread of inflammation along the tubes to the adjacent peritoneum. Although that, to a certain extent, may be regarded as an accidental complication of fibroid tumour, yet, I think it is promoted by the fibroid; for, in many cases, the fibroid tumour interferes with the cavity of the uterus, producing distortions and twists in it, and so, any secretion which may gather in the interior, being unable to escape freely, aggravates any existing catarrh and promotes its extension to the peritoneum. In cases of peritonitis complicated with fibroid of the uterus, the chief inference to be drawn is that if any operation is likely to be necessary or expedient at all, it should be undertaken within a comparatively short time from the attack of inflammation. It is best, as a rule, to wait for comparative quiescence and normal temperature, but not to wait until the adhesions set up by the peritonitis have become firm and solid and extremely difficult to separate. I think experience has shown that the most difficult possible cases of operation for fibroid tumour of the uterus have been those in which there has been old standing pelvic inflammation, and in which the growth of the tumour has been chiefly subsequent to that inflammation. For there you will not only find the appendages bound down, but the adhesions which have formed appear to tie the whole of the uterus down to the pelvis, and lead the tumour to spread into the broad ligaments, and strip up the peritoneal membrane.

Another form of inflammation occurring in these cases of fibroid tumour is phlebitis, beginning generally with thrombosis of the veins. This is a comparatively common complication of fibroid tumour of the uterus, and in all probability the chief causes which bring it about are, first, the change produced in the blood by the presence of the tumour. That will be chiefly anæmia due to hæmorrhage, a condition which leads to a greater proneness for the blood to coagulate. Possibly in addition to that, there is some other chemical change in the blood arising from necrosis or inflammatory conditions in the tumour. Another important element is the effect of pressure obstructing the iliac and the femoral veins, especially if the tumour spread into the broad ligament.

I would not say that phlebitis is an absolute indication for an operation in all such cases, for I have known its occurrence near the menopause to be the starting point for progressive improvement and a diminution of the tumour. But a recurrent phlebitis would be an indication for an operation, and even a single attack of it, if combined with other serious symptoms.

The next question is the nature of the operation to be advised. In the case of a small tumour, the first question to consider is that of oophorectomy. This method is now by some authorities denounced altogether, and it is held that much the better operation is to remove the uterus with the tumour, and leave one or both ovaries. But for my own part I still hold that in suitable cases oophorectomy is a good and successful operation; and the main ground on which I recommend it is that its mortality is less than that of hysterectomy, provided it is undertaken in those cases for which it is suitable, and those I hold to be cases in which the fibroid tumour is not larger than the uterus at from three to four months' pregnancy. The mortality of oophorectomy in cases of fibroid tumour has been variously put at from two to five per cent., or even more. I myself think that two per cent., or even considerably less, if the operation is limited to suitable cases, is a more correct proportion; and in my own practice

I have not met with any fatal result where the tumour has been of such small size as I have described, and where the patient has not suffered from peritonitis. If there are serious peritoneal adhesions, it is preferable to remove the tumour and not merely the ovaries.

The comparative mortality of hysterectomy is rather difficult to estimate. You cannot well compare the mortality in the hands of different surgeons, because some would advise the operation in all cases of fibroid tumour of the uterus; others would follow what has been our practice here, and only recommend the operation in very serious cases, mostly in those of very large tumours, in which, of course, an operation is much more dangerous. Obviously, those who operate in almost all cases of a disease not generally fatal in itself, ought to have a very low mortality. In some recent statistics, Mr. Bland Sutton, who is a prominent advocate for hysterectomy in almost all cases of fibroid tumour, gives a series of cases, with two deaths out of twenty-eight, or a mortality of 7·1 per cent. That was obtained by the modern mode of operation which is known as the intra-pelvic treatment of the pedicle. The old plan of performing hysterectomy was to clamp the pedicle formed by the neck or lower part of the uterus, fix it with pins in the abdominal wall, and leave the stump to slough away. It has not yet been proved, perhaps, that the other plan has an actually less mortality. In the discussion on Mr. Bland Sutton's paper, Mr. Meredith, who was long an advocate of the older method, and one of the latest to give it up in favour of the other, reported a series of ninety cases of operation by the clamp method, with a mortality of seven, or 7·7 per cent. That is a degree of mortality which differs very slightly from that of Mr. Bland Sutton.

A word as to the advantage of this modern method. It appears to have a mortality which is at least as low as that of the older method of operation, and the future experience of operators may be expected to show still further improvement. But the operation itself is a much more satisfactory one surgically, as it allows of more rapid convalescence to the patient, and less risk of subsequent inconveniences. The effect of allowing the stump to slough is that you often get a certain amount of disturbance from absorption during that process. Moreover, there is prolonged convalescence, since the separation of the pedicle after a fortnight or so leaves a great gap to granulate up, and the site of this is liable to be a weak point in the abdominal wall, and give rise to future ventral hernia. On the other hand, after hysterectomy by the intra-pelvic method, the patient recovers quite quickly; she is usually pretty well at the end of a fortnight, and may go out at the end of three weeks, and have a perfectly firm abdominal wall in which there is no possibility of ventral hernia arising.

This modern operation is generally known as Baer's operation, Baer being a surgeon in New York, who was not by any means the first to introduce the intra-pelvic treatment of the pedicle, but who did introduce a particular element in the operation, which, I think, is a very important improvement, and which has been followed by most recent operators. It consists in securing all the vessels outside the uterus, and not putting ligatures of any consequence in uterine or myomatous tissue at all. The disadvantage of the previous plan is that such tissue behaves badly under the ligature, and is liable to slough or suppurate when constricted, or to shrink and allow bleeding. The most essential point about this operation, therefore, is the securing of the uterine arteries outside the walls of the uterus. In doing that I generally use this semi-blunt pedicle needle, curved in one plane, with large eyes which can easily be threaded. For transfixing very deep in the pelvis this other pattern of pedicle needle, curved in a plane oblique to the handle, is often convenient. For simple rotation of the handle brings the eye, carrying the ligature, easily within reach.

The most convenient clamps for placing on the tumour on the distal side of the incisions are these, which are known as Doyen's clamps. You see the points meet before the middle portion of the blades, and as the handles are compressed the blades become parallel, and hold firmly throughout their whole length. The plan which I adopt is to transfix the broad ligament by a double ligature just within the ovarian vessels, either above or below the position of the ovaries, as may be desired. One loop is made again to pierce the broad ligament close to its edge, the other loop encloses the free edge, and the ovarian artery is thus doubly secured. The rest of the broad ligament is then cut across till the uterine artery is approached, and any vessels that bleed are secured.

As to the question of leaving one or both ovaries, the same point is involved as in the decision between hysterectomy and oophorectomy, and the tendency of modern times, which, I think, goes rather to an extreme, is to be very reluctant to remove both ovaries. In removing the uterus, in a great majority of cases, if the

operation is undertaken comparatively early, you can leave one or both ovaries by dividing the broad ligament between ovary and uterus. The object of that is to obviate any impairment of sexual power which the removal of the ovaries might be supposed to produce. The same reason is one of the arguments urged against the choice of oophorectomy, in comparison with hysterectomy, for fibroid tumours of moderate size.

The influence on sexual power of the removal of the ovaries, has, I think, been much exaggerated, and more especially so in its application to cases of fibroid tumour. From what I have been able to learn on the subject by enquiries from husbands, I believe that fibroid tumour is generally associated with a greater than the average development of sexual susceptibility, and that even if both ovaries are removed, the patient who has a fibroid tumour of the uterus will, at any rate for many years to come, have a greater sexual power than women in general. Therefore, the removal of both ovaries is not so serious a loss as is sometimes supposed. For my own part, I have, in several instances, performed the operation of oophorectomy purely with a view to the marriage of the patient in cases in which the symptoms were not so urgent that they would have led her to consent to an operation apart from the prospect of marriage. The result has been entirely satisfactory both to husband and wife. Therefore, if hysterectomy has to be undertaken, I think it is an alternative which should be left to the patient whether she would have both ovaries removed or not.

I cannot say that, in cases of fibroid tumour, I have observed any serious disorders follow the removal of both ovaries. I had, not very long ago, the opportunity of operating in the case of two sisters, both of whom suffered from fibroid tumour, and in both of whose cases I recommended an operation. The elder sister had a large fibroid, and the younger sister a comparatively small one, from which she was not suffering very much, but from seeing the suffering of her sister she consented to have oophorectomy performed. The elder sister, who had very much shrunk from the risk of any operation, at the end of a year or so was so extremely pleased at the result of the operation on her younger sister, that she agreed to have her uterus removed, and this was done with equal success. The result has been that perfect cures have followed in both cases, and I have not been able to discern any difference in the result between the one who had the uterus removed, and the one who had her ovaries removed.

There are some instances, however, in which you cannot very well, without risk, leave the ovaries behind. If the tumour has got into the broad ligament, you sometimes could not do so without leaving a very long pedicle, which might cause a band producing intestinal obstruction. And in these fibroid tumours it is common to find an abnormal state of both ovaries; they are often enlarged by hyperplasia or cystic degeneration, so much so as to suggest that the condition of the ovaries may have excited the growth of the fibroid tumour. In such cases, unless the patient is very anxious to have the ovaries saved, I should prefer strongly to remove both of them.

I think it is a question whether the symptoms which follow the menopause are any less in those patients in whom the menopause has been brought on by removal of the uterus, than in those in whom it has been brought on by removal of both ovaries. If one ovary is left, a menstrual nisus still occurs. The patient may suffer inconvenience in that way, and even have a slight menstrual discharge from the little bit of mucous membrane left. It should be remembered, too, that it is not so many years ago since it was thought necessary, in many cases of patients who had congenital absence of the uterus, to remove the ovaries for the cure of a menstrual nisus, which was supposed to give additional trouble, simply because there was no uterine discharge at all. In one such instance I removed both ovaries—I found only a rudimentary uterus—with great benefit to the patient. It seems to me that a remaining ovary without the uterus is not found to be such an unmixed benefit to the patient as some authorities consider it to be.

After securing the ovarian vessels the next step is to cut through the peritoneum in front, half an inch above the bladder, and strip it down, carrying the bladder with it. Then you have to search for the uterine arteries, which can be felt pulsating. If the tumour has not spread into the broad ligament, these will be found here (indicated), but if the tumour has spread into the broad ligament, the vessels will generally be found lying in front of the tumour. In order to secure the arteries, you must go down below the level of the tumour in the broad ligament, enucleating it, if necessary. If the first clamp has secured only the ovarian vessels, a second clamp is placed close up to the side of the uterus, securing the uterine vessels on the distal side of the line of incision.

A single or double ligature is then placed around the uterine artery on each side by transfixing the broad ligament. In doing this it is desirable to pass the needle through the anterior layer of peritoneum, which has been stripped down, as well as the posterior. This isolates the broad ligaments from the pocket which is formed above the stump of the cervix.

In cases where the fibroid is in the neck of the uterus, the only way of carrying out the operation, according to this particular plan, is to make a transverse incision right through the fibroid imbedded in the neck, and then enucleate the remnant of the fibroid, which leaves a cup-shaped depression, with the os uteri at the bottom of it. But in more ordinary cases your section is across the cervix or the lower body of the uterus, which is only moderately enlarged. If your ligature on the uterine artery is sufficiently low, in comparison with the line of incision across the neck, you get comparatively little bleeding from the small vessels. If bleeding cannot be stopped by the pressure of forceps for a minute or two, the plan I have adopted is to put, with a fine curved needle and No. 1 silk, a figure eight ligature, securing the bleeding vessel superficially; then, if the main vessel is properly secured, you get no more bleeding.

The remaining step is to sew up the gap in the peritoneum. That is done either by interrupted or continuous sutures, so that you form a pocket in the peritoneum which covers in the raw surface of the stump of the cervix, the broad ligaments being closed over in a similar manner.

The chief risk in such an operation is that where the cavity of the uterus is septic you may get infection from the cervical canal. I generally prevent that by mopping it down with some antiseptic. Or if there is any reason to suppose it to be septic, the whole cavity of the uterus may be syringed out beforehand.

As a general rule no drainage of any sort is required in these cases unless there have been extensive adhesions to the surface of the tumour. You cover in everything, uniting the peritoneum, and there is nothing left bleeding in the peritoneal cavity. If bleeding does occur, it is into the pouch, and it generally has a mode of escape through the cervix uteri. I will now read brief notes of the four cases which we have recently had in Queen ward.

Case I.—Anne H., æt. 35, was admitted into Guy's Hospital, November 8th, 1898. She had been married eleven months and had a premature delivery at the sixth month, nine weeks ago. After delivery, a mass was felt which was at first thought to be a second fœtus, but examination under anæsthetic showed it to be a fibroid tumour presenting at the os uteri.

During the whole of pregnancy she was losing off and on in a very irregular manner, and hæmorrhage has continued ever since. Before the pregnancy menstruation was irregular and too frequent.

On admission, a median pyriform swelling is found reaching up to umbilicus, and resembling the uterus at five months' pregnancy. *Per vaginam* the cervix is found to be closed, lying far back; the tumour depresses the anterior vaginal wall.

On November 23rd an examination was made under an anæsthetic. The sound was passed five inches, posterior to the tumour. The cervix was then dilated with Hegar's dilators up to No. 22. The tumour could then be felt projecting into the cavity of the uterus, attached nearly as low down as the internal os, to the front and right side of the uterus. The capsule was divided along the lower margin of the tumour, and the tumour separated from the uterine wall as far as the finger could reach, in the hope that the uterus would gradually extrude the mass. The cervix, however, contracted again, and the mass did not descend. It was decided to remove the tumour on account of the hæmorrhage, and its situation low down in the uterine wall. The operation was performed on December 8th, the cervix having been dilated with tents, in the hope that enucleation would thus be rendered possible. As it was found that sufficient room could not be obtained, abdominal hysterectomy was performed. The only peculiarity about the operation arose from the distended condition of the cervix. In consequence of this the tumour was excised by a V-shaped incision, and the edges of the cervix as well as the peritoneum were brought together by sutures, so as to shut off the peritoneal cavity from the vagina.

The tumour weighed three pounds two ounces. The main mass was found to be subperitoneal, only bulging slightly into the cavity. The tumour, on section, was found to be in an advanced state of necrosis, apparently aseptic in character. The amount of detachment appeared to be too slight to have damaged its vitality, and there was no sign of any inflammation extending from the uterine cavity. The patient recovered without any disturbance.

Case II.—Mary C., æt. 42, single, was admitted into Guy's Hospital, January 30th, 1899.

She first noticed a tumour a year ago, and since then it has increased rather rapidly. Up to the last month menstruation had been regular, lasting four to five days, profuse. About two dozen diapers are used at each period. A fortnight ago pain commenced in tumour, accompanied by hæmorrhage, coming on shortly after the end of a period. The loss continued up to date of admission, and a week ago amounted to flooding.

On admission.—A hard median abdominal tumour was found reaching nearly up to umbilicus. It extended broadly into the flanks and was very fixed. There was a dark tarry-looking, bloody discharge from vagina, which was small, with an intact hymen. The tumour was felt to bulge the anterior vaginal wall, and to extend to both sides of the pelvis. The sound passed nearly six inches behind the main mass, the point turning forward.

The patient was anxious for a radical cure, and hysterectomy was chosen in preference to oophorectomy, on account of the size of the tumour, the pain felt in it, and the irregular hæmorrhage.

The operation was difficult and prolonged, on account of the tumour spreading into the broad ligaments on both sides. The bladder had to be stripped down for a considerable distance in front, and the tumour enucleated on both sides before the uterine arteries, which lay in front of the tumour, were secured. After removal of the tumour, the edges of peritoneum were stitched together over the exposed cellular tissue of both broad ligaments, and the stump of the uterus was covered over with peritoneum separately. Though the operation lasted two hours, there was very little collapse, and the patient recovered with hardly any disturbance.

The tumour lay entirely in the anterior wall of the uterus. On section, a large cavity was exposed, containing ℥xvi. of thick fluid of a dark chocolate colour. The cavity was lined by a thick layer of dense tissue, looking at first sight like malignant growth, but containing no milky juice. On microscopic section it proved to be infiltrated with round cells, apparently inflammatory.

Case III.—Elizabeth L., æt. 46, was admitted to Guy's Hospital, January 7th, 1899. She had been married twenty years, and had had no pregnancy. For the last two years menstruation had become excessively profuse, painful and too frequent, recurring sometimes a fortnight after the commencement of the last period. Three months ago she suffered from severe pain in left groin and across back. The bowels are usually constipated, and there is pain on defæcation. A swelling in abdomen was first noticed three months ago.

On admission.—A median, hard tumour is felt, reaching up to one inch below umbilicus. It is freely moveable, and connected with cervix uteri like a peg-top mass, with the cervix as peg. The sound passed four inches. The patient was exceedingly blanched. The operation presented no special difficulty, and the patient recovered without disturbance, the temperature never reaching 100°. The tumour proved to be a multiple fibroid. The left ovary was considerably enlarged by a unilocular cyst. The right contained a recent corpus luteum of menstruation. In this case the indication for operation was the amount of hæmorrhage and its severe effect upon the patient.

Case IV.—Caroline O., æt. 48, was admitted into Guy's Hospital on December 7th, 1898. She married three years ago, at the age of 45, and has had no pregnancy.

Menstruation is generally regular and profuse, lasting at least a week, and it has been getting more profuse for the last ten or twelve years. There is much leucorrhœa between the periods.

Seven years ago she had an attack of phlebitis in both legs, affecting the left leg first. She was laid up for nearly ten months, and at this time an abdominal tumour was discovered. A month ago the left leg began to swell, and it has been gradually becoming more swelled, and intensely painful.

Micturition has been difficult for a long time, but she has had no retention. The bowels are very confined, and she is troubled with piles which have bled much of late.

On admission.—A firm abdominal tumour is found, lobulated, and reaching one inch above umbilicus, spreading widely into right flank. The cervix is displaced forward and upward, and the tumour bulges down the posterior vaginal wall, reaching within two inches of the vulva. The rectum is displaced to the left and flattened by pressure. The left leg is very greatly swollen, white, and pits only slightly on pressure.

Pyrexia continued for a fortnight after admission, temperature ranging from 101° to 103°. After this the patient gradually improved and the swelling of the leg diminished. Hysterectomy was advised on account of the size of the tumour, its pressure in the pelvis, and the recurrent phlebitis.

The operation was performed on January 30th, 1899. It was found possible to turn out the mass in the pouch of Douglas, which was an external fibroid. The chief difficulty was found

in dealing with the right broad ligament, which was bound down by adhesions to the pelvis and to the right ovary, which was greatly enlarged. The tumour weighed 5½ pounds and measured 7 by 6 by 4 inches. The largest fibroid was in posterior wall of uterus, and this was cystic on section from mucoid degeneration.

The patient recovered from the operation without any constitutional disturbance. She had, however, a purulent discharge through the cervix uteri, beginning about the seventh day, and lasting several days. I feared that the ligatures might become septic, but this has not proved to be the case. Thus is shown the advantage of isolating the pocket above the stump from the broad ligaments and leaving no ligatures in it. The pocket had doubtless become infected from the cervix uteri.

I have another specimen here which will show you how this same mode of hysterectomy may be applied to another operation, namely, that for removal of ovarian tumour, in some cases of extreme difficulty. The tumour was deep in the right broad ligament, burrowing under the cæcum, and extending between the uterus and the bladder, having stripped up the peritoneum. The usual treatment in these cases is to enucleate the ovarian tumour out of its sac, leaving the outer sac which is stitched to the abdominal wall. That, of course, means a long convalescence while that cavity granulates and heals up.

In this instance it proved impossible to separate the cyst wall into two layers, or to enucleate the lining. I therefore removed the whole of both broad ligaments and the fundus uteri, including the left ovary, which was in an earlier stage of cystic tumour. The separation of the bladder was so difficult that a rent of two inches was made at the summit. The sewing up of this, and covering in the whole floor of the pelvis with peritoneum, rendered the length of the operation nearly three hours. The patient, however, is recovering without disturbance, the rent in the bladder has given no trouble, and her convalescence will be much more rapid than if the capsule of the tumour had been stitched to the abdominal wound, while she will escape having a weak place in the abdominal wall, involving risk of ventral hernia.

Presentation.—On February 18th, in the Board-room of Dulwich College, Mr. E. R. Ray, M.R.C.S. Eng., on the occasion of his leaving the neighbourhood of Dulwich, was presented with a silver bowl and salver, together with a cheque for £116. This testimonial was largely subscribed by Mr. Ray's patients, many of whom had received his advice and attention for a period of thirty years.—*Lancet.*

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Pye-Smith.

Philip	22.	Acute rheumatism. Pericarditis. Systolic apical murmur. Double conjunctivitis.
	23.	Bronchitis and emphysema.
	26.	Morbus cordis. Mitral incompetence.
	27.	Aortic obstruction and regurgitation. Mitral regurgitation.
	31.	Right hemiplegia. Probably cerebral hæmorrhage.
	33.	Bronchitis. Apical systolic murmur.
	35.	Empyema. Aspirated.
	36.	Addison's disease.
	37.	Bronchitis.
	40.	Diabetes.
Mary	28.	Diphtheria. Tracheotomy.
	34.	Pleurisy and effusion.
	37.	Aortic stenosis. Mitral stenosis and regurgitation.

Cases under Dr. Shaw.

Stephen	5.	Pleurogenous fibroid pneumonia.
	9.	Stricture of ureter. Operation. Suppuration.
	11.	Aortic and mitral regurgitation.
	12.	Syphilitic ulceration of tonsils. Application of nitric acid.
	14.	Abdominal tumour. Exploration.
	18.	Old empyema, with small opening. Lardaceous disease. Resection of two ribs.
	19.	Fibroid phthisis at right apex. Syphilitic ulceration of hand.
Mary	39.	Tuberculous tumour of left crus cerebri.
	42.	Carcinoma of stomach.
	48.	Mitral stenosis. Embolism of right arm and left leg.

Cases under Dr. Hale White.

Philip	2.	Chronic tubal nephritis.
	4. 11.	Hæmoptysis.
	7.	Typhoid.
	10.	Appendicular abscess. Operation.
	12.	Gout (aged 10).
	14.	Sub-acute tubal nephritis.
	15.	Chorea.
	17.	? Plumbism. ? Growth. Cystitis.
	18.	Gout, acute. Granular kidneys. Alcoholism.
	20.	Aortic stenosis. General atheroma (abdominal aorta). Granular kidney. Glycosuria.

Mary 15. Mitral regurgitation. ? Stenosis. Tricuspid regurgitation.
17. Appendicitis.
18. Hemiplegia.
Cot 53. Convulsions. Rickets.
19. Peripheral neuritis.
20. Appendicular abscess. Operation.
21. Carcinoma of pylorus and liver.
22. Hæmaturia.
24. Hysteria.

Cases under Dr. Pitt.

Mary 1. Phthisis.
3. Fatty degeneration of heart.
6. Mitral stenosis and granular kidney.
9. Pneumonia. Recovery.
10. Chlorosis.
11. Empyema. Operation.
Stephen 21. Tubercular peritonitis.
22. Pleuritic effusion.
24. Bronchiectasis. Fibroid lung. Empyema
26. Pericarditis.
27. Abdominal tumour. Hydatid of liver.
28. Mitral and tricuspid disease.
29. Abdominal tumour.
33. Broncho-pneumonia.
34. Chorea.
35. Abdominal tumour. ? Growth of colon. growth of kidney.
36. Mitral and tricuspid disease.
37. Locomotor ataxy.
38. Adherent pericardium.

"Clinical."

John 1. Convulsions.
6. Gumma of liver.
15. Fibroid lung. Ascites. Albuminuria.
16. Immersion.
Miriam 17. Oxalic acid poisoning.
23. Aneurysm.
27. Rheumatic fever.
29. Hydatid of liver.
30. Appendicitis.
31. Mitral stenosis and regurgitation.

In the Surgical Wards.

Cases under Mr. Howse.

Astley Cooper 2. Fractured mandible.
17. Fractured femur.
18. Subcoracoid dislocation of shoulder.
21. Compound fracture of femur.
22. Depressed fracture of vertex. Convulsions. Bone raised.
23. Fractured femur and humerus.
25. Fractured ribs and clavicle.
Astley Cooper 29. Fractured ribs. Pleurisy.
31. Fractured ribs with emphysema.
Cot. Fracture of both clavicles.
Naaman 1. Æt. 37. Undescended testis and con genital hernia. Castration and radical cure.
14. Enlarged prostate.
17. Infantile paralysis. Excision of knee.
18. Otitis media. Cerebral (temporo-sphenoidal) abscess. Death.
18. Sarcoma of metatarsus. Enucleated.
Charity Cot E. Mastoid abscess.

Cases under Mr. Davies-Colley.

Luke 2. Recurrent melanotic sarcomatous glands. Excised.
6. Recurrent cutaneous sarcomata. Excised.
9. Angeiosarcoma of tarsus and metatarsus and tibia. Syme's amputation.
Lydia 1. Thyroid cyst. Enucleated.
3 and Cot A. (Twins). Rachitic femora and tibiæ: osteoclasm.
9. Epithelioma of vulva and inguinal glands. Excised.
17. Antral empyema. Drained.
18. Strangulated femoral hernia. Kelotomy.
20. Carcinoma mammæ and glands. Patient æt. 39. Eight months pregnant.
Cot D. Septic wound of scalp. ? Necrosis. Hernia cerebri.

Cases under Mr. Lucas.

Job 5. Spinal caries with sinus. Scraped.
21. Fibroma of heel. Excised.
25. Undescended testis and phimosis.
Charity 1. Tuberculous tarsus.
2. Carcinoma mammæ.

Cases under Mr. Golding-Bird.

Astley Cooper 7. Cut-throat and bullet wounds in head. Death.
15. Fractured jaw.
18. Fractured ribs.
Cornelius 1. Fractured jaw.
2. Compound fractured humerus.
3. Fractured ribs.
Martha 3. Ventral hernia after ovariotomy. Radical cure.
17. Spontaneous compound fracture of tibia.
22. Carcinoma mammæ.
Cot A. Ranula. Incised.
Cot B. Tuberculous dactylitis of toe.
Cot E. Fractured femur.
Lazarus 9. Tuberculous tarsus (affecting calcareo-astragaloid joint). Syme's amputation.
11. Stricture.
12. Rectal prolapse.
13. Cystitis and enlarged prostate.

Lazarus 15. Æt 24. Cleft palate.
18. Lupus and tuberculous knee.
20. Caries of scapula.
21. Tuberculous elbow.

Cases under Mr. Jacobson (Mr. Fripp acting).

Victoria 1. Umbilical hernia: radical cure.
4. ? Rectal stricture.

Samaritan 11. Senile gangrene of foot. Stephen Smith's amputation.

Cases under Mr. Symonds.

Patience 14. Tuberculous pyosalpinx. Pelvic abscess. Fæcal fistula.

Luke 16. Excision of carcinomatous rectum.
17. Old ruptured urethra admitted for closure of perineal sinus.

Martha 13. ? Tuberculous os calcis with sinus. ? Tuberculous bursitis.

Cases under Mr. Lane.

Job 14. Old Pott's fracture.

Victoria 5. Malunion of fractured radius.
6. Old dislocation of hip. New joint formed.
7. Tuberculous metacarpus.

Cases under Mr. Dunn.

Martha 11. ? Carcinoma mammæ. ? Chronic mastitis.

Lazarus 1. Epithelioma of tongue.
2. ? Epithelioma of floor of mouth. ? Inflammatory.
3. Bilateral cysts of epididymis: excised.

In Lighter Vein.

The Rugger Cup Final served amongst other things to emphasize the moribund condition of the Trumpet and Rattle Custom. In my young days all the best people carried fearsome musical instruments, whereas on this occasion this was confined to a few London men. True, one blade brought a Megaphone; now a Megaphone in capable hands has great possibilities, but to go to the trouble and expense of carting an instrument like that all the way to Richmond, and then to find nothing better to do with it than to shout "Rats" and "What Oh!" down it is merely a criminal waste of opportunity.

One of the persons who use a part of the Medical School Buildings was recently invited by a kind-hearted resident to join the festive gathering in the Charities' Room after dinner. On arrival he was offered some coffee. "Cawfee!" he ejaculated, with a tinge of scorn. "No thanks. Why I've only just 'ad dinner!"

Everyone who knows anything of the Conjoint Board is aware that Mr. Hallett is always willing to look into and adjust any complaints that are put before him. Now, I have a grievance to air. On a recent visit to that fascinating place, the Hall by the River, I encountered a college servant who addressed me as "Sir!" If this was not an unwarranted piece of gross politeness I should like to know what is. Candidates for examination are in such a state of nervous tension that the least they can expect is to be treated with becoming insolence by the menials. However, as this is the only instance of common politeness, it should be easily rectified, but Mr. Hallett must be vigilant.

People sometimes wonder at the number of prematurely bald and grey-headed men there are among medical students; and they like to explain the phenomenon by "the life they lead." The true explanation lies in the mental aggravation involved by interviews with a certain type of patient. The following is a fairly typical sample:—

Student. "What's the matter with you?"

Patient. "Matter with me? That's what I come 'ere to find out?"

S. Well, what do you complain of?"

P. "Oh, I don't *complain*. 'Taint much use complainin', is it?"

S. "Well, have you got any pain anywhere?"

P. "N–o–o! Not to say *pain* you know."

S. "Do you sleep well?"

P. "Not 'arf."

S. "Eat well?"

P. "I'm sure!"

S. "Do your feet ever swell?"

P. "Well, there you are yer see!"

S. "I didn't ask you where I was, I asked you if your feet ever swelled."

P. P'r'aps at times they might swell, but I've never noticed 'em."

S. "Who d'you suppose would notice them if you don't."

P. "Bad job about that, aint it?"

S. "Now, look here! How long have you been ill?"

P. Oh, I ain't ill — not to say *ill;* not in myself."

S. "How long have you been unwell, then?"

P. "Oh, some time."

S. "How long? Some days or some years?"

P. "I couldn't tell you—not exactly."

S. "Well, say a week?"
P. "No, it wouldn't be a week."
S. "Six days, perhaps."
P. "No, it would be more than that."
S. "A month, then?"
P. "I dunno. I'm no scholard."
S. "Well, what the dickens do you come here for, anyway?"
P. "Come 'ere for? I want treatment."
S. "What do you want treated?"
P. "That's what I come 'ere to find out."

And so on, till at last it turns out that some misguided philanthropist has given the patient a Letter of Recommendation, and he sees no reason why he should not use it. Then does the student order him Mist. Asafœtidæ Effervescens and Liquor Epispasticus to be applied between the shoulder blades.

Once upon a time our "Smokers" were known as the best in London, nowadays they are "postponed indefinitely." Guy's still leads the way.

As a set-off to the above it must be remembered that the Nurses' Choral Society has given two successful concerts this season. We can't have everything.

At some hospitals the winning of the Rugger Cup would have incited a Smoker. But we are not as other hospitals.

An Occasional Note in the *Pall Mall Gazette* of March 14th says: "The valour of the hospitals has not yet found its songster either of the drawing-room or the music-hall order. . . . There are many less taking subjects for a ballad than the cruel kindnesses of the surgery or dissecting-room." This paves the way for me nicely. Here is the drawing-room version:—

My soul is sad within me,
My head is bowed in woe
For oh, my love has left me,
And the tears unbidden flow.

He fell sick in the springtide
With an influenza cough,
And the ambulance came next morning
And bore my loved one off.

But one bright spark of comfort
Gleams forth in the glowering gloom,
cres. For I know that the nurses watch by him
In the warm dissecting-room.
f Yes, I know that the nurses watch by him
ff In the warm di-issecting-room!

If the above sonnet meets with the success it deserves, I will break out into a music-hall version shortly. A.

Guy's Pharmacopœia, 1899.

A FORECAST.

We all think that what is done at Guy's is better done than elsewhere. In the matter of the Pharmacopœia there is no doubt that this is so. Guy's Pharmacopœia has been compiled with the object of serving as a guide to the prescriber. It is not merely a collection of formulæ in use at Guy's Hospital, but the British Pharmacopœia, 1898, is included so far as it is necessary to be known for the purpose of prescribing. The old Guy's man finds our Pharmacopœia an absolute necessity. In the last edition everything has been brought up to date, and the latest information given upon such matters as Diphtheriæ Antitoxinum, etc.

The work is on the same plan as the Pharmacopœia of 1891. The arrangement is an alphabetical one, the Guy's preparations being underlined.

Diphtheria Antitoxin is fully described, the value of the unit stated, and the method of injection given. Capsules of Creosote, Sandal Wood Oil, and Terebene are introduced. The list of Gauzes has been extended by the addition of Carbasus Aseptica, Cyanidi, and Iodoformi. There is an additional Tooth Powder, Dentifricium Cretæ Compositum, flavoured with oil of cinnamon. Emulsio Iodoformi is a new preparation. In the B.P., 1898, there are no formulæ for enemas. It is certainly necessary that there should be some definite information regarding this class of preparations. Most of the enemas of the B.P., 1885, are now included in G.H.P. There are two new formulæ for gargles, Gargarisma Formaldehydi and Resorcini. Glycogelatinum Zinci is a preparation largely used at Out-Patients. Guttæ Pilocarpinæ and Guttæ Atropinæ Fortes are the additions to the list of Eye Drops. The new hypnotic Trional is introduced under the form of Haustus Trional. The formulæ of the Insufflationes are written for the quantity to be used for one insufflation. Insufflatio Iodoformi is the only new one. The formula of Linctus Opiatus is considerably altered, and a useful remedy for troublesome coughs, Linctus Codeinæ, is added. Lotio Chinosol, Formaldehydi, and Lysol are new antiseptic lotions. Liquor Salinus is a solution of sodium chloride for intravenous injection.

Guy's was in possession of some very ancient formulæ for mixtures. As remedies they were excellent, but they were not in accordance with modern tastes, which demand that medicines shall be elegant and pleasant. The old Julep Rhei has gone. It was a thick mixture of powdered rhubarb and calumba. The modern Mist. Rhei Co. contains the up-to-date Liquor Rhei and Liquor Quassiæ Concentratus. It is transparent and elegant in appearance. Mistura Ammoniæ no longer contains treacle, but clarified honey. A solution of citric acid replaces lemon juice in the effervescing mixtures. The standardized Ext. Nucis Vomicæ Liquid. goes into Mist. Acidi Co. and Mist. Armoraciæ Co. Mist.

Ferri et Quininæ is a solution of Ferri et Quin. Cit. in water. Mist. Guaiacol contains a remedy for pulmonary tuberculosis. Mist. Ol. Morrhuæ et Hypophosphitum is an emulsion of cod liver oil with the hypophosphites of sodium and calcium. Mist. Salol contains salol suspended in mucilage mixture. There are three new formulæ for pigments, Pigmentum Acidi Chromici, Acidi Sulphurosi, Hydrargyri Comp. The formulæ for all pills are now written to four grains, so that the dose is four to eight grains, as in the B.P., 1898. Liquid Glucose and a mixture of tragacanth, water and syrup of glucose, called Glucantha, are two new excipients used. The new pills are Pil. Colocynth cum Hydrarg., Ferri Arsenicalis, Ferri Iodid., and Hydrarg. Iodidi Virid. An asthma remedy has been introduced, Pulvis Lobeliæ Compositus; it is composed of Potass. Nit. Lobelia, Stramonium Leaves, and Anise. Dose: the fumes of one drachm of the burnt powder by inhalation. The ointments appearing for the first time are Ung. Adipis Lanæ Comp., Calomel with Morphine, Olei Theobromatis, and Glycerini Comp. Vapor Creosoti and Olei Pini, omitted from B.P., 1898, are inserted in Guy's. Vaselinum Cupri Sulph. and Iodoform are two new eye ointments. The only addition to the formulæ for children is Mist. Ammoniæ et Ipecacuanhæ.

H. COLLIER.

Reviews.

An Atlas of Bacteriology. By Chas. Slater, M.A., M.B., etc., and Edmund J. Spitta, L.R.C.P., etc., pp. 120. (Scientific Press) 7s. 6d. nett.

This Atlas contains one hundred and eleven microphotographs, all more or less excellent, with explanatory text. We doubt very much the utility of such a book. The authors lay great stress on the cheapness, and with this we quite agree. Considering how well the photographs have been reproduced, and how excellently the book has been published, it is cheap.

The authors hope that it will become a laboratory handbook, that it may help the teacher, and that it may find a place in the library of the medical officer of health and the practitioner. For the author's sake we hope it may, but we cannot think that it will.

The student learning bacteriology should be trained to observe for himself. All illustrations for the purpose of elucidation should be diagrammatic. On comparing a number of the photographs together we found, as we expected, that many so nearly resembled one another that the student would become confused.

The teacher who has to rely on a series of photographs cannot know much of his subject; and to the M. O. H. we cannot see of what use it could be. If he was competent to undertake the bacteriological work of his district, he would not need such an atlas; if he needed such a work, he would be incompetent.

The few photographs of cultures which figure in the atlas did not remind us of the organisms named. No one would imagine, for instance, from fig. 44, that the streptococcus on gelatin was a delicate and small growth.

We think that, good as some of the photographs are, the authors might well have devoted their time and talents to something of more practical use.

Chapel News.

The Church Council met last week and decided to adopt the design of Messrs. Percy, Bacon & Bros., for the central panel of the reredos. The cost of this will be £90. Donations will be thankfully received by either of the Treasurers of the fund, Mr. F. Shufflebotham and the Rev. L. B. Sladen. The rough draft of the design can be seen in the Chaplain's Room.

It is hoped that the two side panels will be in their places by Easter. The money for them (£60) has already been subscribed.

Services during Holy Week.—Palm Sunday: Holy Communion, 7 and 8.40 a.m.; Morning Prayer and Sermon, 11 a.m.; Evening Prayer and Sermon, 7 p.m. Monday, Tuesday, Wednesday and Thursday: Holy Communion, 7 and 8.40 a.m.; Evening Prayer, 5 p.m.; Prayers and Meditation, 8.15 p.m. Good Friday: Evening Prayer and Sermon, 8.15 p.m. Easter Eve: Preparation for Easter Communion, 10 a.m. and 9.50 p.m. Easter Day: Holy Communion, 7 and 8.40 a.m.; Preacher at 11 a.m., the Rev. F. H. Rice; Preacher at 7 p.m., the Rev. L. B. Sladen.

Society of Apothecaries of London.

Five Years' Curriculum.

SURGERY EXAMINATION.

Notice is hereby given that after July 1st, 1899, Operative Manipulation and Surgical Anatomy will be included in Section I. of the Final Examination; leaving Section II. entirely Clinical.

FRANK HAYDON, L.R.C.P. Lond.,
Secretary.

Papers by Guy's Men.

Valedictory Address on "Opinion the Salt of Fact." Delivered before the Harveian Society. By James F. Goodhart, M.D. Aberd., F.R.C.P. Lond.—*Lancet*, 28th January.

A Lecture on Medical London. By E. Baxter Forman, M.D. Brux., M.R.C.P. Lond., L.C.C., J.P.—*Ibid.*

"THE GUYOSCOPE."

Passim.

Fortune has favoured Guy's again this year. On Tuesday week last we beat London Hospital in the Final Tie by 9 points to nil, thus keeping the cup for another year. The game was a good hard one throughout, and no doubt the better team won, though in the last quarter of an hour our forwards were hard pressed, but never dangerously, owing to our excellent defence.

It was the value of good defensive tactics that Mullins laid great emphasis on later in the evening, at the dinner given to the Fifteen by the Residents. He pointed out that in the last two years the Guy's line had never been crossed in cup ties. Guy's had made 76 points in these two years, and 8 points had been scored against us, viz., a drop goal and a goal from a mark. The mere mention of this fact is sufficient tribute to the soundness of our defence. The crowd down at the match was as large a one as we have ever seen, but it was comparatively quiet, with the exception of a few musical enthusiasts on the side of the ground opposite the stand. As is pointed out in another column, the day for a continuous accompaniment of musical instruments, foghorns and police rattles is past. The majority of our Staff were present, but apparently very few of the London Hospital Senior Staff.

On Tuesday last, on the St. Thomas's Hospital Ground, at Chiswick Park, the Association 2nd XI. defeated St. Bartholomew's Hospital, in the Final Round of Junior Association Cup, by 3 goals to 2. Evidently football is going strong this year at Guy's.

The Hospital has to thank Mr. Bonsor for another generous benefaction. The Treasurer has promised to lay the Colonnade with glass mosaic at his own expense; a scheme which will very greatly improve the appearance of the surgical buildings. It is probable that the work of relaying the Colonnade will not be commenced till the heavy work of doing up the surgical wards is completed.

It is a matter of public regret and almost disgust, that the second Smoking Concert arranged for this year has ignominiously fallen through. Whether the fault lies with those who are responsible for its management, or whether it lies in the direction of lack of talent we cannot discuss here, but it is deplorable to think that a large hospital like ours, once famous for the best smoking concerts in London, should have sunk to such a state of inanition as the present.

We are able to definitely announce that the new edition of the hospital Pharmacopœia will be published in the first fortnight of April. It will be brought into line with the B.P., 1898, and will be issued in the same shape and binding as hitherto. The prices are:—

	s.	d.
Leather, interleaved	2	6
" uninterleaved ...	2	0
Cloth, uninterleaved	1	6

The caricature, from the well-known pen of Mr. Stanley Cock, which we publish to-day, is his impression of Mr. J. M. Fortescue-Brickdale, editor of the *Guyoscope* in the second and more prosperous year of its short career.

It has been suggested that a personal column should be started in the Gazette, to enable past and present Guy's men to learn to some extent the whereabouts and doings of their former friends at the hospital. The chief obstacle to the realization of this idea is the difficulty of collecting the news, as it never strikes men to send gratuitous information about themselves. If, however, when men run across the path of a man well-known and popular in his day who has disappeared from view, they would let us know, we could publish the news for the benefit of all who read the Gazette. It is obvious, however, that from our fixed position up here, and from the ephemeral sojourn of each successive editor, that unless news is sent up, we cannot by ourselves collect it, but we are only too glad to give the scheme a trial.

The three nurses of Guy's Hospital Staff who went out to West Africa a year ago have been paid a very high compliment in a report from Dr. Poole to Major Lugard. The former attributes all the recent recoveries of blackwater fever under his charge to their care, and Major Lugard thought that those at Guy's who knew them would like to hear of this appreciation of their services. The nurses in question were Nurses Nutt, Clarke, and Powell.

In future the House Committee will meet every Thursday morning, instead of Wednesday morning as heretofore.

The beds in the Surgical Wards have now been arranged among the various surgeons. Messrs. Howse and Jacobson will take Naaman and Dorcas; Messrs. Davies-Colley and Symonds, Job and Lydia; Messrs. Lucas and Lane, Lazarus and Martha; and Mr. Golding-Bird, Luke and Charity. By this arrangement practically each surgeon gets eighteen male and eighteen female beds and three cots, and each assistant surgeon four male and four female beds and one cot. In addition to the beds thus allotted, three beds in Job ward and two beds in Ruth have been assigned to Throat cases under the care of the surgeon in charge or the throat department. The change over of the patients will take place in the last week of March and first week in April.

In reply to an enquiry from a Subscriber, we beg to state that the fee charged by the Clinical Research Association for testing milk for tubercle bacilli is 10s. 6d. to members and 15s. to non-members.

We have received no Nursing News from any official source for this number of the Gazette. According to the old proverb, no news is good news, and we hope it is true in this instance. The more probable cause of this dearth of information is that those in authority are nursing the sick, for influenza is claiming many victims just at present. We are glad to be able to say that Nurse Carey, who is in Clinical with typhoid, is better and going on very well.

Applications are invited for the post of Ophthalmic Registrar and Tutor, which will become vacant by Mr. G. Bellingham Smith's resignation on May 1st, and should be addressed to the Treasurer, Superintendent's Office, not later than Saturday, April 1st.

Notice.

ARTHUR DURHAM PRIZES FOR DISSECTION.

Second Year's Students.—The Prize has been awarded to Mr. C. H. Robertson and Mr. A. H. E. Wall, equal, £7 10s. each.

First Year's Students.—The Prize has been awarded to Mr. A M. Webber, and Certificates to Messrs. N. Ivens Spriggs and C. D. Pye-Smith.

Guy's Hospital, March 13th, 1899.

Pancreatic Inflammation and Hæmorrhage.

A Paper read before the Physical Society on Saturday, November 26th, 1898, by Mr. W. T. Milton.

Mr. President and Gentlemen, — The subject of Pancreatic Inflammation and Hæmorrhage is one of exceptional interest on account of the obscurity which still surrounds it, and the strong resemblance presented by the symptoms of this condition and those of other acute abdominal lesions. It is of peculiar interest both to the physician and the surgeon, for they meet here on common ground, and almost invariably their joint powers of diagnosis are found wanting. The reason for the obscurity of the disease is obvious, inasmuch as the condition, although not so rare as was at first believed, is decidedly uncommon, its symptoms are deceptively like those of acute intestinal obstruction, and the organ affected is so deeply placed as to be almost inaccessible to those methods of examination which are principally relied on in the diagnosis of other abdominal lesions.

Schmackpfeffer, as early as 1817, reported the case of a syphilitic woman who died while undergoing a course of treatment by mercury. At the autopsy he found the pancreas swollen, red and inflamed, and regarded this as a condition of inflammation secondary to parotid changes induced by the mercury.

Clässen, in 1842, collected the records of six fatal cases which he regarded as instances of pancreatic inflammation, but of these six, four might well be explained on other grounds, and the evidence on behalf of the remaining two was insufficient to put the diagnosis beyond doubt.

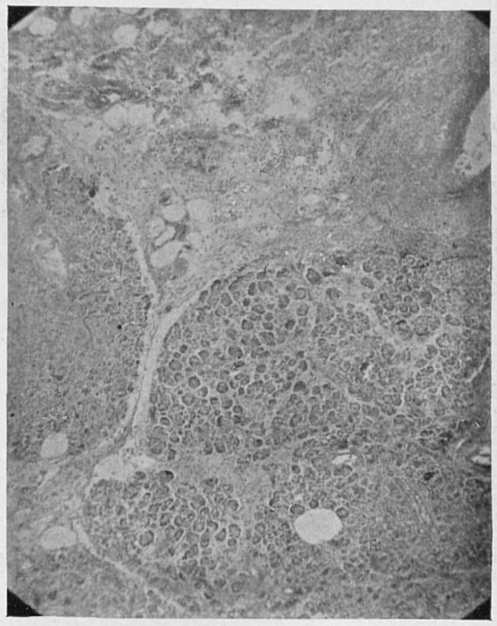
Klebs, in 1870, acknowledged the association of pancreatic hæmorrhage with severe symptoms; he also recognized as a rare occurrence the existence of a hæmorrhagic inflammation of the pancreas, which might in some cases result in a purulent peri-pancreatitis with sequestration of the gland.

Friedreich, in 1875, thought that the pancreas might be affected in two ways. He thus recognized a primary acute pancreatitis characterised by a tendency to hæmorrhage into the substance of the gland and its immediate surroundings, and which might terminate in suppuration or gangrene; and a secondary form in which he included a condition of granular degeneration met with in infective diseases, and those cases in which the pancreas was the seat of a metastatic abscess.

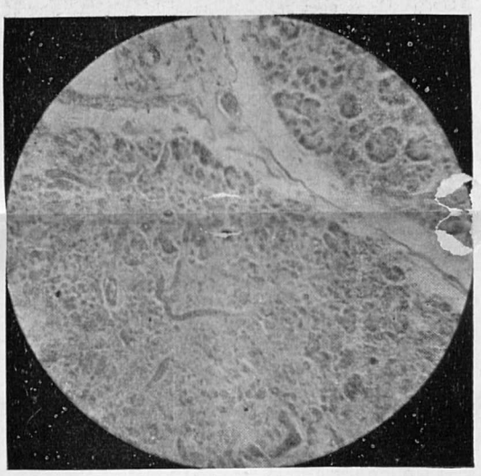
Klebs, on the other hand, denied the existence of a pancreatic abscess not arising from a peri-pancreatitis or a suppurating cyst.

Chiari pointed out that a peri-pancreatitis might originate from a perforated gastric ulcer, and described a case in point. He also recorded two other cases, in which the sloughing pancreas was discharged from the bowel.

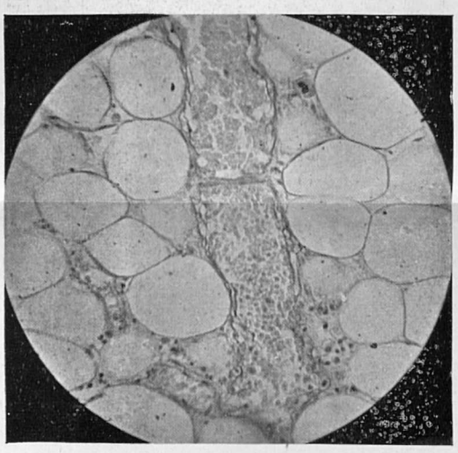
Acute Hæmorrhagic Pancreatitis.
Fat Necrosis. Zeiss A.



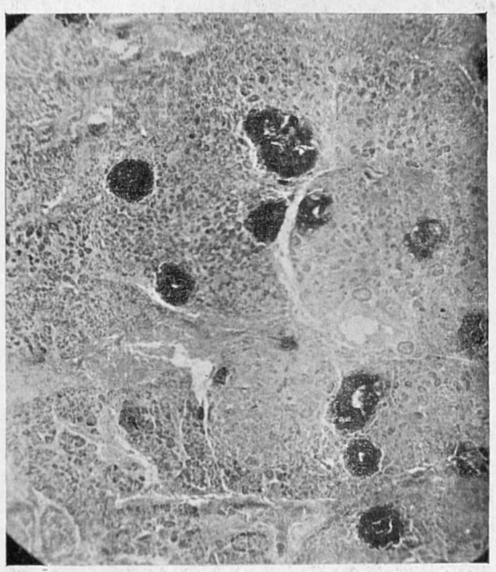
Acute Hæmorrhagic Pancreatitis.
Normal and Necrotic Lobule side by side. Zeiss A.



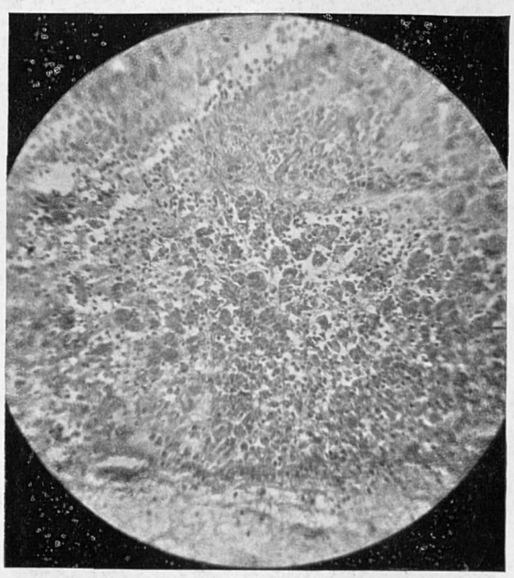
Acute Hæmorrhagic Pancreatitis.
Portions of Normal and Necrotic Lobules. Zeiss D.



Acute Hæmorrhagic Pancreatitis.
Fat Necrosis. Zeiss D.



Acute Hæmorrhagic Pancreatitis.
Circumscribed Hæmorrhages into substance of gland. Zeiss A.



Acute Hæmorrhagic Pancreatitis.
Small, round-celled Infiltration between degenerate Pancreatic Acini. Zeiss D.

PANCREATIC INFLAMMATION AND HÆMORRHAGE.—By Mr. W. T. Milton.

It was not until 1882, that Balser drew attention to the association of pancreatic inflammation with the presence of nodules and patches of necrotic fatty tissue in the mesentery and subperitoneal fat. In another case which he recorded, there were, besides the patches of fat necrosis, evidences of old and recent hæmorrhages within the gland tissue.

But the credit for first accurately describing the ætiology, symptoms, pathology and morbid anatomy of this interesting disease undoubtedly belongs to Fitz, who, in 1889, read his memorable Middleton-Goldsmith lecture before the New York Pathological Society. He reviewed the history of the affection up to the then present date, of which the above is a brief abstract, and then from a series of cases drawn partly from the records of other observers, partly from his own experience, he described in minute detail the particulars of this obscure affection. He subdivided his paper into a consideration of (1) pancreatic hæmorrhage; (2) acute hæmorrhagic pancreatitis; (3) suppurative pancreatitis; (4) gangrenous pancreatitis; and (5) disseminated fat necrosis. He put upon permanent record sixteen cases of pancreatic hæmorrhage, seventeen of hæmorrhagic pancreatitis, twenty-two of suppurative and fifteen of gangrenous pancreatitis. He came to the following conclusions, best described in his own words:—

"*Pancreatic hæmorrhage* is an uncommon affection, and there is nothing in sex, habits, condition, or exposure which will indicate the likelihood of its occurrence. Pain is an early symptom, is usually severe, often intense, and is to be found in the abdomen or lower chest. Although mention is made of its presence in the epigastrium, this region is not conspicuously designated as the seat. On the contrary, there may be little or no pain, or merely a sense of constriction of the chest. Nausea or vomiting is but occasionally mentioned; constipation or diarrhœa is still more rarely noted. The most constant symptoms are those of collapse and are more or less intense, and more or less prolonged. Death may occur as early as half an hour after the first onset, or may be deferred for thirty-six hours."

"*Acute inflammation of the pancreas* is both a well-characterized disease and one which is much more frequent than is generally thought. It is of great consequence that it should be recognized for the following reasons:—

(1). It represents a serious complication of what, by itself, is a relatively simple affection, viz., gastro-duodenitis.

(2). It is an important cause of peritonitis, and one readily overlooked.

(3). It has been repeatedly confounded with acute intestinal obstruction and has thus led, in several instances, to an ineffective laparotomy, an operation which, in the early stages of this disease, is extremely hazardous."

"*Method of origin.* — Acute pancreatitis commonly originates by the extension of a gastro-duodenal inflammation along the pancreatic duct. It may also be induced by the occurrence of hæmorrhage in the pancreas. This may be of traumatic origin, although usually arising from unknown causes. The pancreatic hæmorrhage may, likewise, be secondary to inflammation of the pancreas."

"*Pathological anatomy.*—The anatomical varieties are the suppurative, hæmorrhagic, and gangrenous. The first may be acute, but is usually sub-acute or chronic, the second is usually per-acute or apoplectiform. The gangrenous variety runs an acute course."

"*Suppurative pancreatitis* may result in an evacuation of the abscesses into the stomach and duodenum, or they may open into the cavity of the great omentum, which, transformed into a large peritoneal abscess, may in turn open into the digestive tract. Pylephlebitis and abscesses of the liver may result. Disseminated fat necrosis is comparatively infrequent."

"*Hæmorrhagic pancreatitis* usually proves fatal in from two to four days. The gross lesions are then those of hæmorrhage within and near the pancreas, extending into the subperitoneal fat tissue, perhaps as far as the pelvis. Peripancreatitis may be expected and disseminated fat necrosis is common."

"*Gangrenous pancreatitis*, although it may be secondary to a perforating inflammation of the gastro-intestinal or biliary tracts, usually results from a hæmorrhagic pancreatitis and is fatal in the course of a few weeks. The gangrenous processes extend to the para-pancreatic tissues, and produce more or less complete sequestration of the pancreas. The peritoneal wall of the omental cavity becomes inflamed, that covering the pancreas may be destroyed, and the sequestrated gland may lie in the omental cavity soaked in pus and attached only by a few shreds. Both pus and pancreas may be discharged into the intestine. Splenic thrombo-phlebitis is not uncommon, but hepatic abscesses are rare. Disseminated fat necrosis is frequent."

"*Symptoms.*—The common symptoms of acute pancreatitis are sudden, severe, often intense epigastric pain, without obvious cause, in most cases followed by nausea, vomiting, sensitiveness and tympanitic swelling of the epigastrium. There is prostration, often extreme, frequent collapse, low fever and a feeble pulse. Obstinate constipation for several days is the rule, but diarrhœa sometimes occurs. If the case does not end fatally in the course of a few days, recovery is possible, or a recurrence of the symptoms in a milder form takes place, and the characteristics of a subacute peritonitis are developed."

"*Diagnosis.*—The symptoms are essentially those of a peritonitis beginning in the epigastrium, and occurring suddenly during ordinary health, without obvious cause. The diagnosis, therefore, is based on pain, tenderness and tympany, limited to the region of the pancreas, and on the gradual development of a deep-seated peritonitis in the same place."

"The differential diagnosis lies practically between an irritant poison, perforation of the digestive or biliary tract, and acute intestinal obstruction. An *irritant poison* is excluded by the history of the case and the examination

of the vomit. *Perforating ulcer of the stomach or duodenum* is to be excluded by the absence of pain after eating, hæmorrhage from the digestive canal, and cachexia. Acute perforation of the transverse colon is rare, and the resulting peritonitis progresses more rapidly, and is likely to be general. Perforation from gall-stones is usually preceded by attacks of biliary colic and jaundice, while the seat of the pain is rather in the region of the gall-bladder than in that of the pancreas."

"*Acute intestinal obstruction* is most likely to give rise to doubt. It is to be eliminated by determining through injection the patency and capacity of the large intestine, by the rarity in the epigastrium of an obstructed small intestine, by the immediate presence of localized tenderness, and by the usual absence of a conspicuous general tympany or limited distension of intestinal coils."

"*Treatment.*—It is evident that all treatment at the outset can be nothing but palliative. With the formation of pus in the omental cavity comes the opportunity of the surgeon. The possibilities of the successful removal of the gangrenous pancreas is suggested by the healthy condition of a patient seventeen years after he had discharged this organ from his bowels."

Since Fitz read the paper which will for ever associate his name with this disease, there have been recorded in the principal English and American medical journals thirty-one cases of pancreatitis; of these, three were cases of gangrenous pancreatitis, two of suppurative pancreatitis, the remaining twenty-six showing the characteristic appearances of pancreatic inflammation and hæmorrhage. In addition to these there have been in Guy's within the last nine months, two cases of acute hæmorrhagic pancreatitis which illustrate in the clearest manner the misleading nature of the symptoms, the difficulty in diagnosis, and the utter futility of treatment in this interesting disease.

Time will not allow of the consideration of suppurative or gangrenous pancreatitis, except in so far as their relation to disseminated fat necrosis is concerned. A brief digest of the cases above mentioned is highly interesting for the purpose of comparison with the conclusions formulated by Fitz.

Thus, as regards the *ætiology*, seventeen of the cases occurred in males, nine in females, the sex of the remaining two not being recorded. Fitz, out of thirty-one cases found that twenty-four were males, seven were females.

The *age* varied from nine months to sixty-three years, the average being thirty-nine years. With the exception of the nine months infant, all were adults. In Fitz' series the average age was forty-five, all being adults. Alcoholism does not seem to have been a marked predisposing factor, inasmuch as only five were mentioned as having been addicted to alcohol during life; this is also in agreement with Fitz' conclusions.

As regards previous intestinal trouble, a history of such was obtainable in ten cases, but was in most of these of a very vague description. Twelve were recorded as having been more or less corpulent.

The *symptoms* differed in no essential particular from those described by Fitz. The onset was commonly sudden and unexpected, the patient being at the time in a usual state of health. It consisted of sudden violent pain, situated usually in the epigastric region, and followed quickly by nausea, vomiting, and collapse. The pain as a general rule was constant, but in a few instances the symptoms began with slight abdominal pain which soon passed off, but was followed sooner or later by the more typical violent epigastric pain, which persisted in greater or lesser degree till death. The seat of the pain was in most of the cases the epigastrium; in one instance the symptoms were ushered in by intense pain in the cardiac region, while in two others constant pain in the "small of the back" was also complained of.

Tenderness in the upper part of the abdomen was commonly met with, but in not a few it was definitely stated that no abdominal tenderness existed.

In a few of the cases *vomiting* preceded the epigastric pain, in others it did not supervene for some considerable time. Thus, in the case of a woman, admitted into Miriam in the early part of the present year, the patient, although suffering from nausea, was not actually sick until after an anæsthetic had been administered for exploratory laparotomy, so that in this case the vomiting might well be attributed to the anæsthetic rather than as the result of a morbid process.

The vomited matter consisted chiefly of bile-stained stomach contents. In one instance a small quantity of blood was voided at the outset. In three of the cases the vomiting ultimately became fæculent, while in a fourth the vomited matters were described as consisting of intestinal contents.

The *condition of the abdomen* as regards distension, mobility, etc., varied within wide limits. Distension might be altogether absent, it might be slight and merely consist in an indefinite fulness in the epigastrium, or, again, the whole abdomen might be in a condition of tympanitic distension. In some instances the abdomen only became markedly distended in the later stages. In one isolated case the abdomen was described as being retracted. Marked abdominal rigidity was usually absent.

Constipation was one of the most constant symptoms noted. As a general rule no natural action of the bowels occurred after the first onset of the pain. In one case, however, on the third day of the illness, and shortly before death, diarrhœa ensued, blood and mucus being present in the motions. In another instance the bowels moved just before death.

The *temperature* followed no constant rule; subnormal temperatures were common, especially in those cases in which collapse was a marked symptom. In others, again, moderate degrees of pyrexia were noted, the temperature ranging from normal to 103°, while in one instance it ran up to 104° just before death.

Diagnosis.—No better illustration of the difficulties surrounding the diagnosis of this obscure condition could

be given than the fact that of three cases admitted into Guy's during the last few years, abdominal section has been performed in each for the purpose of relieving a suspected intestinal obstruction.

Osler, in his "Principles and Practice of Medicine" claims that "the admirable studies of Fitz . . . have brought the affection within the scope of the diagnostician," probably basing this statement upon the fact that Fitz, within a week of reading his paper, correctly diagnosed a case as one of hæmorrhagic pancreatitis. In this particular instance, the majority of the consultants favouring intestinal obstruction as the correct diagnosis, abdominal section was performed, and at the operation patches of fat necrosis were evident in the omentum, but no mechanical obstruction could be found. At the autopsy the usual appearances of hæmorrhagic pancreatitis were revealed.

Thayer, in 1895, recorded a case in which he made a correct diagnosis of pancreatitis. In this case, however, the diagnosis was simplified by the presence in the epigastrium of a localized tympanitic tumour, which, when drained, proved to be a para-pancreatic abscess; the patient recovered.

Soon after this Körte and Atkinson both reported cases in which a correct ante-mortem diagnosis was made, but in each case the presence of an epigastric tumour materially assisted the diagnosis. Körte's case died eight days after operation, while in Atkinson's case no operation was performed, the woman surviving for twelve weeks.

Milnes, in 1897, published a case which he believed to be one of pancreatitis, but as the patient recovered, and that without operative interference the diagnosis could not be verified. The symptoms in this case were somewhat anomalous, the abdomen being markedly retracted during the course of the illness.

Turning to the series of cases under consideration, in no fewer than eleven out of twenty-eight was abdominal section performed for the relief of a suspected intestinal obstruction. In addition to these, one patient died on the table during the first stages of anæsthesia, while in three the collapse was stated to have been so profound that any thought of operative interference had to be abandoned.

In one particularly interesting case, that of an infant aged nine months, recorded by McPhedran, symptoms of intestinal obstruction were present, and in addition, an elongated mass could be felt over the region of the ascending colon. Intussusception was diagnosed, and at the operation undertaken for its relief, the mass was found to be an accessory lobe of the liver. Post-mortem the pancreas and its surroundings were deeply infiltrated with blood.

In another case, that of a stout woman, aged fifty-nine, who gave a history of "biliousness," and who presented the usual train of symptoms, a diagnosis of biliary colic was made. Death occurred within twenty-four hours of the first onset, and post-mortem a small gall-stone was found impacted in the bile duct, but in addition the pancreas was deeply engorged with extensive hæmorrhage into its tissues.

A diagnosis of aneurysm of one of the branches of the coeliac axis was made in the case of a man aged thirty-two, who suffered from abdominal pain which was sudden in its onset, sickness, constipation and collapse. An indefinite pulsating swelling could be seen occupying the epigastric region, the pulsations not being expansile in character. A loud rasping murmur was audible over the swelling, and at each beat a loud splash could be heard over the stomach region. The character of the respiration was such as to suggest that the mass was exerting pressure upon the under surface of the diaphragm. At the post-mortem examination the mass was found to consist of a large quantity of blood-clot, apparently retroperitoneal, in front of the aorta, and so far as could be determined originating from the head of the pancreas. The latter organ microscopically showed signs of disease.

Prognosis.—Although the disease appears at first sight almost uniformly fatal, it must be remembered that, generally speaking, it is only on the post-mortem table that the true diagnosis is revealed, and it is quite possible that milder attacks of abdominal pain which clear up under treatment, may be due to transient inflammation of the pancreas, or slight hæmorrhage into its substance. In some of the cases under consideration a definite history was obtained of a previous attack of abdominal pain accompanied by symptoms resembling in all particulars save intensity the later fatal attack.

In one such instance, in which the first attack occurred some years before the second, Simon found the pancreas surrounded by fibrous thickening, which he attributed to the former attack. That recovery is possible without suppuration or sloughing of the affected gland is also proved by Osler's case, in which the diagnosis was only discovered during the performance of abdominal section, the patient recovering both from the disease and the operation. Finally, past records have clearly shown that in cases which have progressed to suppuration or gangrene, evacuation of the pus by surgical methods, or of the necrotic gland per rectum has been followed by recovery; in Trafoyer's case the patient was alive seventeen years after the evacuation of the sequestrated pancreas by the bowel.

Post-mortem appearances.—Excessive adipose tissue, subcutaneous, subperitoneal, etc., although present in a good many cases, was not invariably met with.

The pancreas in the great majority of instances was enlarged, its consistency varying, the gland being in some cases indurated, in others more friable than normal. The most characteristic appearances where those due to hæmorrhage, which was almost invariably met with. No constancy was noted with regard to the extent of the bleeding. In a few of the cases the hæmorrhage led to the formation of large retroperitoneal extravasations extending laterally to the kidneys and in a downward direction almost to the pelvis. In the majority of instances the hæmorrhage was slight and confined to the root of the mesentery, the subcapsular tissues and

glandular substance of the pancreas. In the latter position it might form a localized collection, forcing apart the pancreatic lobules, or exist as a diffuse infiltration throughout the substance of the gland. In one case recorded by Simon no evidence of hæmorrhage could be found, but the pancreas was infiltrated and its lobules surrounded by an opaque, dead white, necrotic substance. Clinically it was a case of pancreatitis, and microscopical examination of the gland revealed decided inflammatory changes.

In connection with the strong resemblance presented by the symptoms of this disease and those of acute intestinal obstruction, it is interesting to note that in one case, that in which aneurysm of the coeliac axis was suspected, the lumen of the duodenum was flattened and obstructed by the pressure exerted by the mass of blood-clot.

A somewhat similar case was mentioned by Fitz, in which the pancreas was much enlarged, and so wedged in between the spleen and the duodenum as to totally obstruct the lumen of the latter.

Microscopically hæmorrhage, inflammation and necrosis were the chief morbid appearances noted. Hæmorrhage was both circumscribed and diffuse, the latter existing chiefly in the interlobular connective tissues, but also extending between the acini where, in some instances, the individual red blood-cells could be readily distinguished. Evidences of older hæmorrhages in the shape of collections of pigment granules, and orange-coloured blood crystals, were not uncommonly met with. The inflammatory nature of the lesions was proved by the existance of small round-celled infiltrations in the interlobular connective tissues and between the pancreatic acini. Degenerative changes were commonly present, evidenced by failure on the part of the gland cells to take up the stain, and in many instances whole lobules appeared to have undergone coagulation necrosis. In a minority of the cases catarrh of the duct epithelium was observed, and in one instance an extensive fibrosis of the gland was apparent.

Multiple disseminated necrosis of the subperitoneal fat was noted in fourteen cases out of twenty-eight. In these cases numerous small rounded opaque-white patches were seen dotted about the root of the mesentery, the omentum, the peritoneum covering the pancreas, kidneys, etc., and lining the abdominal wall. Cutler recorded one case in which, in addition to the subperitoneal fat necrosis, areas of necrosis were observed in the fatty tissue of the mediastinum and upper surface of the diaphragm.

The necrotic areas were characterized microscopically by the presence within the affected cells of granular material, and by failure of the cell nuclei to stain. In some instances the cells were occupied by delicate feathery crystals. Normal and necrotic cells existed side by side, and occasionally a definite band of small round-celled infiltration could be made out surrounding the necrotic areas.

Changes in the stomach and duodenum were quite exceptional. Simon recorded two cases in which he found this part of the alimentary tract diseased; in the one the stomach and duodenum showed marked catarrhal changes, both to the naked eye and microscopically. In the other the stomach was acutely inflamed, and hæmorrhagic, and the duodenum showed microscopically an inflammatory infiltration of its coats. In the third case reported by Reynolds and Moore, the first part of the duodenum was inflamed, the mucous membrane being in a necrotic condition, and the submucous and muscular coats infiltrated and congested. In a fourth case, that of a man found lying dead on a sofa, and in whom post-mortem examination revealed the presence of a large hæmorrhagic extravasation into the head of the pancreas, the stomach was acutely inflamed, but this observation is discounted by the fact that on analysis this organ was found to contain a large quantity of chloral and morphia. In still another case ecchymosis round the cardiac end of the stomach was the sole lesion of the intestinal canal found.

In three cases only were gall-stones present in the bile duct, and in two of these the stone was found blocking the termination of the common duct, one of them actually projecting into the duodenum.

General suppurative peritonitis co-existed with the pancreatic lesion in only one case. A slighter, more localized plastic peritonitis was more commonly met with, but in the majority of cases the peritoneum showed no marked inflammatory changes.

Pathology.—Like other obscure conditions, the literature concerning the pathology of this disease abounds with theories, some impossible, others plausible, but none altogether satisfactory. Schmackpfeffer, as already stated, in one particular case regarded the pancreatic changes as secondary to parotid inflammation. In this instance, however, the evidence was insufficient to put the diagnosis of pancreatitis beyond doubt. Even had it been a true instance of pancreatitis the possibitity of the occurrence of parotitis during the course of a pancreatic inflammation would have been difficult to disprove.

Nevmann, writing in 1836, stated that "death might take place within a few hours from a fatal metastasis of the buccal salivation to the pancreas. This happens when, in the midst of profuse salivation, the pulse sinks and quickens, or the swelling of the salivary glands subsides, and salivation is replaced by a green diarrhœa, while the skin is dry and shrunken."

Fitz was of opinion that pancreatitis was secondary to a gastro-duodenitis, the infective process spreading along the pancreatic duct from the duodenum. Against this view is the fact that in less than half of the cases under consideration could any history of previous digestive troubles be obtained, while in the great majority no signs of any morbid process affecting the stomach and duodenum could be discovered post-mortem. In the list which Fitz collected, and from which he drew his conclusions, only six out of seventeen gave any history of previous gastric trouble, and in only one were any changes in the stomach and duodenum noted after

death. That pancreatitis may occasionally be secondary to changes in the upper part of the intestinal tract is supported by the two cases recorded by Simon, the post-mortem appearances of which have already been described.

Balser thought that the pancreatic changes were secondary to fat-necrosis, which he regarded as the primary disease.

Other observers incline to the belief that pancreatitis is an acute infective process analogous to the involvement of the parotid in mumps, and dependent upon the entry of a specific micro-organism, either through the duct or by means of the blood-current.

Some cases have been found associated with the presence of gall-stones in the biliary tract, and this has naturally led to the suggestion that the pancreatic inflammation might be a secondary result following the impaction of calculi in the common duct. This theory does not throw any light on those cases in which no gall-stones were found, and which constitute the greater part of the list.

Traumatism appears to have been the causative agent in a few instances, as in the case of a man who was admitted into Guy's a few years ago for abdominal injury caused by the shaft of a cart, and who died a few days later after presenting signs of localized peritonitis. At the autopsy, the omentum and mesentery were found studded with areas of fat necrosis, and the pancreas was in a gangrenous condition, and showed signs of cavitation.

Numerous theories have been put forward to account for the bleeding in cases of simple pancreatic hæmorrhage apart from pancreatitis. Some authorities compare pancreatic with cerebral hæmorrhage, both as regards the laxity of the tissues in which the blood vessels are embedded and the age and class of people in whom both lesions occur. Others prefer to ascribe it to a degenerative condition of the walls of the smaller vessels supplying the pancreas, to the rupture of aneurysmal dilatations, to embolism, fatty degeneration of the gland tissues, etc. That it is not secondary to necrosis of fatty tissue is proved by the fact that in those cases in which death ensued very rapidly, and which Fitz preferred to call pancreatic hæmorrhage rather than hæmorrhagic pancreatitis, fat necrosis was very rarely met with. Klebs suggested that in the absence of inflammatory changes in the interstitial tissue, the hæmorrhage might be attributed to the corrosive action of the pancreatic secretion. In discussing this point Fitz mentions as suggestive evidence the fact that in the dead subject arterial injections are likely to break through and escape in the region of the pancreas. That the hæmorrhage is frequently secondary to the inflammatory process in case of hæmorrhagic pancreatitis is admitted by most authorities, but the converse is also doubtless true, the hæmorrhage often being the primary cause of the inflammation.

Death may occur with appalling suddenness in cases of simple pancreatic hæmorrhage, and in these instances the hæmorrhage is often found to be trifling in amount, and obviously insufficient to explain death merely as a sequence to the loss of blood. Most observers are agreed that in these cases death is probably due to involvement of the great abdominal sympathetic ganglia, which lie in close relation to the head of the pancreas.

Zenker, in two out of three cases of fatal pancreatic hæmorrhage, described a striking venous injection of the solar plexus and regarded this as the immediate cause of death, which he compared, as regards its mode of production, with the cardiac paralysis produced experimentally by Goltz by a blow on the frog's abdomen.

Osler, reporting a case in 1887, described an increase in the number of round cells in the semilunar ganglia, the ganglion cells of which were cloudy and indistinct. He also noted an œdematous condition of Pacinian corpuscles behind the duodenum and pancreas.

In most of the cases reported subsequently to this, the condition of the sympathetic ganglia has not been recorded, so that the question is still an open one, but it is interesting to note that most of the prominent symptoms, collapse, pain, vomiting, and constipation, are explicable on the grounds of sympathetic implication.

The *pathology of fat necrosis* has been approached from both a clinical and an experimental standpoint. Hooper was the first to note the crystalline contents of the fat cells in a case of pancreatitis.

Ponfick, in 1872, drew attention to the occurrence of a disseminated necrosis of bone marrow in a case of empyema and lardaceous disease.

Balser, ten years later, clearly described the condition of multiple subperitoneal fat necrosis in connection with two cases in which the pancreas was found diseased. He came to the conclusion that "an excessive growth of the fat cells near the pancreas occurs in many men. It may become so excessive, in very fat people, that a large part of the abdominal fat dies, and it thus proves fatal either on account of the quantity destroyed, or the associated hæmorrhage." He thus attributes the necrosis to deficient nutrition, the direct result of the failure of the blood-supply to keep pace with the rapid proliferation of the fat cells.

Chiari, in 1883, recognized the association of fat necrosis with pancreatic disease, but did not agree with Balser as to the causation of the necrosis. He preferred to look upon it as a degenerative process, and admitted that it might be a cause of pancreatic hæmorrhage and thus prove fatal. He denied that the necrotic changes in the fatty tissue round the pancreas could be so extensive as to cause complete sequestration of that gland.

Fitz has described the condition at length. He recorded fat necrosis as a rare event in pancreatic hæmorrhage and suppurative pancreatitis, but as a common occurrence in the hæmorrhagic and gangrenous varieties. He concluded that there were two varieties of fat necrosis, "necrobiotic" and inflammatory. The former he regarded as having no necessary ætiological relationship with pancreatic disease. The latter he looked upon as closely connected with inflammation of

the pancreas, and regarded it as especially important as causing in some cases sloughing of the entire gland. The inflammatory part of the process he attributed to the transfer of infective material either through the blood-current, or by direct inoculation of the peritoneum, the primary source of the infection being the diseased pancreas. He denied Chiari's and Balser's statement that hæmorrhage might be secondary to fat necrosis in view of the fact that in most of the cases of fatal pancreatic hæmorrhage which he recorded no fat necrosis was present. Furthermore, fat necrosis was occasionally noticed in cases of suppurative pancreatitis in the total absence of any hæmorrhage.

Still later Balser and Thayer both agreed that fat necrosis may be found in a considerable number of cases in the interlobular pancreatic fat of individuals who have shown no symptoms pointing to the process during life, and in whom no evidence of pancreatic disease is forthcoming after death. In these cases, however, the necrosis is almost always limited to the interlobular fat tissue of the pancreas.

Writing in 1897, Fitz states that "subperitoneal fat necrosis, combined with evidences of hæmorrhage or inflammation, is almost invariably found in conjunction with pancreatitis, and with it alone. This relation is so constant as to indicate the importance of disease of the pancreas in its ætiology, and to raise a doubt of the thoroughness of the examination of the pancreas in those cases where subperitoneal fat necrosis is stated to have occurred in the absence of pancreatic disease."

At Guy's, subperitoneal fat necrosis has in several cases been noted in association with hæmorrhagic pancreatitis, with gangrenous pancreatitis in one instance, and finally in a case of malignant disease of the head of the pancreas with secondary deposits in the lungs and liver.

With regard to the immediate *causation* of the necrosis, the theories of Balser, Chiari and Fitz have already been stated. Rolleston thought that the change was trophic, depending on a disturbance of sympathetic innervation. Micro-organisms have been thought by some observers to be the primary cause, but in nearly every case investigated, the foci of necrosis have been found sterile. Welch, in 1891, obtained a pure cultivation of the bacillus coli communis from the necrotic areas, but in this case extensive intestinal ulceration was present, and he himself stated that he regarded the bacterial invasion purely as a secondary process. In another case, one of suppurative pancreatitis, no less than four different varieties of micro-organisms were obtained by culture from a patch of necrotic fat, their very number arguing against the specific nature of any of them. Most observers attribute the necrosis to the action of the pancreatic juice, explaining the necrosis of the fatty tissue of the pancreas as a local effect, and that involving the subperitoneal fat as secondary to the extravasation of the pancreatic secretion into the peritoneal cavity.

Körte approached the question experimentally, and reported that fat necrosis was occasionally met with after mechanical injury to the pancreas and its vessels, and especially after laceration of the gland and transplantation of detached portions into the abdominal cavity. An artificially excited inflammation of the gland by means of injections of irritating or infective substances resulted occasionally in the production of fat necrosis.

Langerhans produced necrosis in the subcutaneous fat by injecting finely-divided pancreatic tissue obtained from the rabbit.

Whitney also produced, experimentally, fat necrosis in a dog.

Hildebrand tied off the splenic end of the pancreas in cats, and then ligatured the pancreatic veins in order to hinder the resorption of the collected pancreatic secretion by way of the blood-vessels. Post-mortem he always found areas of fat necrosis, both in the pancreas and the adjacent omentum and mesentery. The same results were obtained by the transference of pieces of pancreas, or the entire organ from one animal into the peritoneal cavity of another, and in one of these cases it is interesting to note that extensive hæmorrhage occurred.

Experimental evidence thus supports the theory attributing the necrosis to the action of the pancreatic secretion.

Turning to the chemical aspect of fat necrosis, Chiari found the larger patches encrusted with calcareous deposits. The inner tallowy material presented microscopically large quantities of acicular crystals, which Harrington pronounced as identical with those obtained from tallow and which he regarded as stearine.

Langerhans, however, states, and his observations have been confirmed by Welch and Barker, that the cell contents in these necrotic patches consist of lime salts of fatty acids. He suggests that a primary lesion of the pancreas allows of the escape of the fat splitting ferment into the surrounding tissues, that this ferment acts upon the normal fat, breaking it up into fatty acid and glycerine, and that the fatty acids thus liberated eventually combine with lime to form the lime salts.

Bacteriology.—The consideration of the bacteriology of the pancreas is interesting, as many observers have sought to associate acute pancreatitis with a bacterial origin. The proximity of the pancreas to, and the direct communication of its duct with an intestinal canal which is teeming with micro-organisms lends colour to this view, but it also raises almost insuperable obstacles to the investigation of any particular variety of organism suspected as being the cause of the disease. The mere fact that after death the gland tissue is found to yield a culture of a definite variety of micro-organism does not prove that that organism is the primary cause of the condition. The invasion of the gland tissue may have taken place either before or after death, and even if it could be proved that the process was an ante-mortem one it must be remembered that the minutest ramifications of the pancreatic acini are in direct continuity with the intestinal canal, so that any inflammation or necrosis of the parenchyma of the gland, apart from bacterial agency, is liable to be followed subsequently by the appearance at that spot of organisms

which have travelled up the pancreatic duct. In this connection the increased activity and virulence of the bacillus coli communis in all inflammatory conditions of the alimentary tract must not be forgotten.

McPhedran, in the case of pancreatitis occurring in the infant of nine months, found only one form of organism present, a bacillus resembling those of the proteus group. In this case, however, the post-mortem examination was not made until forty hours after death, and the pancreas was extensively decomposed, thus rendering worthless any bacterial investigation.

Simon has recorded three cases in which examination revealed the presence of organisms of different character, the most distinctive of which was a somewhat slender bacillus with rounded ends, not staining by Gram's method. The bacillus coli communis was also obtained by culture. Two of these cases were associated with inflammatory changes in the stomach and duodenum. In the case of a woman admitted into Miriam in the early part of the present year, a pure culture of the colon bacillus was obtained from the pancreatic tissue, but whether this was due to ante- or post-mortem invasion of the gland it was impossible to say.

Finally, the question of treatment, to which all these considerations are subsidiary, must be discussed.

Fitz stated that, at the outset, treatment must be palliative, that is to say, pain must be kept in check by morphia, collapse by the use of stimulants, vomiting by the administration of fluid food in small quantities often repeated, or by rectal feeding, etc. Surgical interference is only indicated by the formation of pus in the omental cavity.

This is clearly an ideal line of treatment, and eminently suitable for those cases in which the diagnosis presents no difficulty. But unfortunately these cases are never met with, and the question of prompt operative treatment must always arise in those acute abdominal cases in which the symptoms are strongly suggestive of intestinal obstruction. In only one case has a correct diagnosis of hæmorrhagic pancreatitis been made in its early stages, and even in that instance the abdomen was opened for the relief of a supposed obstruction. With regard to this particular case, the question must arise as to whether Fitz would have maintained his diagnosis to the extent of refusing operative measures, had he been the only consultant present.

The time has not yet arrived when hæmorrhagic pancreatitis can be differentiated from acute intestinal obstruction with sufficient certainty as to justify the surgeon in staying his hand, and until that time does come it is only fair to the patient to give him that chance, faint though it be, which modern surgery holds out to him. It is surely better to operate in a case of hæmorrhagic pancreatitis, than to have the mortification of seeing a case of acute obstruction taken to the post-mortem room with the abdomen unopened. In the former case the operation can only result, at least in the majority of instances, in hastening death by a few hours, while in the latter the loss of a life may be involved.

Sport.

Rugby Football.

GUY'S v. LONDON.

INTER-HOSPITAL CHALLENGE CUP.—FINAL TIE.

Guy's has been particularly fortunate in the way of fine weather for the Cup ties, and Wednesday, March 8th, was as good a day for the Final as could be wished. The big ground was at its best, and what wind there was blew obliquely across it without giving much advantage to either side. The company present was estimated at 2000, and it included many of the staff of the competing Hospitals; of our own we noticed Mr. Davies-Colley, the President of the Club, Dr. Taylor, Mr. Higgins, Mr. Lucas, Mr. Dunn, Drs. Bryant, Fawcett, and many others. Although it was generally expected that our men would win, still, a close game was anticipated, and much interest was evinced in the match since Guy's had not met London in the Rugby Cup Ties for more than seven years, and the latter had done so very well in the preliminary ties, and showed such scoring powers, that it was thought that the chances were great that our clean score sheet would be smudged. However, as it turned out, such did not happen, and for two seasons Guy's has gone through the Cup Ties without having its line crossed once, and this year, no score whatever has been registered by the opposing teams. The actual result, 3 tries to nil in favour of Guy's, is a very fair criterion of the day's play. But for a quarter of an hour in the middle of the second half, our men showed a marked superiority in all points. As a game, it was hardly as good an one to watch as was last year's final; it was not so open in character, and the outside play was hardly so finished as on that occasion. Still, there is nothing whatever to grumble about. As the daily papers said, it was a typical Hospital Cup Tie, which was just what everyone went down with the hopes of seeing.

As in the two previous Cup Ties, Mullins again lost the toss, and Guy's were deputed to kick off from the entrance end, against the gentle breeze. The ball was well returned into touch outside the Guy's twenty-five flag. Sime soon got away, but stuck to the ball too long; he made amends, however, immediately afterwards by giving Hilton a good pass, and the latter looked like scoring straight away, but was well tackled by the London full-back, by name Rudkin. Scrummaging within the London half then became the order, and Crimp and Bousfield were now, as indeed they were all through, conspicuous for excellent saving. By degrees, however, the Guy's pack worked the ball to the London twenty-five, and from a scrum, Wetherell got away and passed out swiftly to O'Brien. From him the ball went to Rae, and he made a splendid dodgy run through a host of opponents, and scored rather wide on the right; O'Brien's kick being unsuccessful. Following the drop-out, which was nullified by a forward being in front of the kicker,

Guy's were quickly attacking again, but Rudkin relieved by an excellent kick, finding touch near the centre flag. Soon after London were obliged to touch down. Just previously, Ayre-Smith had been damaged by a blow in a sensitive region, and the game was delayed for a few minutes. He was unable to at once proceed, but joined the game after a few minutes' rest. Several penalty kicks were awarded London, for "feet up" and "off-side," but the ground lost was quickly regained by excellent forward rushes. Wetherell, Sime and Rae were conspicuous for passing runs, the last named going very near scoring on several occasions. The defence of the London backs, however, was very good, and that, added to a few mulls by our backs, prevented any addition to the score sheet up to half-time, which arrived with Guy's leading by a try to nil.

Very soon after change of ends, Rae made a brilliant run, and had cleared all opposition when he was finely collared by Rudkin, half way between the twenty-five and goal-line. Guy's kept the game here for some time, but the London men defended strongly. Once Philbrick and Griffith, with a nice, passing run, relieved nearly to mid-field, but it proved of little use, as our front rank soon worked their way once again into their rivals' territory, where Wetherell passed out to O'Brien, and then Rae, getting possession, showed a fine turn of speed, and dodging all rivals, scored another try on the right, which O'Brien missed improving by a few inches only. On continuing, only about a minute elapsed ere Guy's were again pressing, but Pye-Smith, when close up, picking the leather out of a scrum, was penalised, and Rudkin, taking the kick, punted grandly into touch by the half-way flag, while a second penalty not long afterwards, enabled them to reach the twenty-five. Here the London men attacked in desperate fashion, but just when they appeared like scoring, a most injudicious kick by one of their forwards sent the leather over the Guy's line, and Ransford had plenty of time to touch down. Nothing daunted, however, London, on resuming, once more assumed the aggressive, and kept play in the Guy's half for a good quarter of an hour, but our men, after a lot of loose rushes, managed to get back to neutral ground, where a drop at goal by O'Brien, ended in the ball going over the London goal-line. In a scramble for possession, too many players tried to save, with the result that Rae, dashing up, secured the ball and scored. O'Brien, however, failed to negotiate. Subsequently the play was of an even nature, both in turn attacking, but nothing further was scored. Result:—

GUY'S	...	...	3 tries
LONDON	...	...	nil.

The teams were:—

GUY'S.—A. C. Ransford (back); F. L. Rae, F. W. Sime, A. O'Brien, C. T. Hilton (three-quarter backs); M. C. Wetherell, C. D. Pye-Smith (half-backs); R. C. Mullins (capt.), D. H. Trail, A. A. Smith, H. A. Cutler, P. T. Manson, A. H. Wall, K. V. Trubshaw, and T. P. Thomas (forwards).

LONDON.—G. F. Rudkin (back); J. H. Philbrick, J. E. Linnell, R. Griffith (capt.), D. G. Lloyd (three-quarter backs); L. Bousfield, G. L. Crimp (half-backs); M. T. Williams, H. H. Cotman, C. H. Morris, C. H. Miller, E. F. Fisher, H. Lett, E. M. Ridge, I. W. Hunter (forwards).

Referee: Mr. Percy Coles (L.R.U.S.R.). Touch judges; Messrs. E. V. Gardner and W. Williams.

REMARKS.—Ransford at full-back played an excellent game, and showed no weak points whatever. At three-quarter, Rae showed that he is not merely a sprinter only, but his first try was gained by most skilful dodging and feinting. He mulled one or two passes, but perhaps that was rather the fault of his confreres, as they hardly seem to make allowance for the pace he is travelling when he receives the ball. Sime and O'Brien played sound games in the centre, and Hilton ran strongly and tackled well. At half, Wetherell was about normal, which means good without being brilliant. Pye-Smith played a surprisingly good game, especially considering the few times he has played in that position. He ought to prove a really good half by next year. He went through in great style on one occasion and reached the full-back, but was unsupported by any three-quarter, and the effort failed. Of the forwards, as a pack they played a hard shoving game and were never beaten. Individually each man showed up brilliantly at one time or another, in fact, the socialists' remark that "one man was as good as another, and a good deal better sometimes," can well be applied to the Guy's forwards. Mullins is to be heartily congratulated on his masterly leading to such a brilliant conclusion.

Of the London men the full back and the halves bore off the chief honours. Rudkin kicked magnificently. Not once during the whole game did he fail to make ground or find touch. His tackling, however, was rather weak, as he should have held Rae on the two occasions in which he ran in. Crimp did a splendid lot of work, and was the chief obstacle to the would-be Guy's scorers.

The referee left no incident of the game unnoticed. He must have had a dry mouth at the conclusion of the eighty minutes play.

WINNERS OF THE CUP.

1874-5 Guy's	1887-8 St. Thomas's
1875-6 St. George's	1888-9 St. Thomas's
1876-7 Guy's	1889-90 St. Thomas's
1877-8 St. Thomas's	1890-1 Comptn. unfinished
1878-9 Guy's	1891-2 St. Thomas's
1879-80 St. George's	1892-3 St. Thomas's
1880-1 St. Bartholomew's	1893-4 St. Thomas's
1881-2 St. George's	1894-5 St. Thomas's
1882-3 St. Bartholomew's	1895-6 St. Thomas's
1883-4 London	1896-7 St. Thomas's
1884-5 London	1897-8 Guy's
1885-6 Guy's	1898-9 Guy's
1886-7 Middlesex	

GUY'S HOSPITAL "A" v. SURBITON.

This match was played at Surbiton on Saturday, February 25th, the ground being in good condition, but swept by a bitterly cold wind which marred the pleasure of a good attendance of spectators, and probably accounted for somewhat erratic handiwork on the part of both back divisions. Guy's team was, on paper, a strong one, but they missed the assistance of F. E. Walker at half-back. In the first-half Guy's played up hill and against the wind, and for the first ten minutes had a busy time defending their own line. By good forward rushes, and a useful kick by O'Brien they worked the game up to their opponents' quarters. Had our forwards played with more dash and secured control of the ball in the scrum, they should have scored at this period, as they seemed to have little difficulty in carrying the scrimmages. Our halves were much hampered by the off-side tactics of the opposing pair, who were, after some time, penalized. O'Brien proceeded to direct the playing of the ball, and ought to have registered a goal, but the referee, harking back to a now obsolete rule, disallowed the kick because the ball had passed through two players hands, and ordered a scrum. Surbiton now transferred the play to our twenty-five, and their fast wing man, Jupp, receiving the ball from his centre, who had been tackled by Sime, managed to outpace the latter and secured a try, but no goal resulted. Guy's again attacked, and narrowly missed scoring from the line out, but good work by the home halves cleared their lines; they were again penalized for off-side play, and O'Brien unsuccessfully tried to drop a goal. At half-time Surbiton was leading by 1 try to nil. On resuming, Guy's by good forward rushes, attacked, but the home three-quarters, getting in some combined work, transferred the game to half way. The ball was again worked back to their lines, and after a series of scrambling scrums, Lawry managed to get over very wide out; O'Brien was ununsuccessful with the kick. Guy's continued to attack although they lost the services of Shannon, his place in the centre being taken by Bagshawe; and Thompson narrowly missed scoring near the touch line. Play continued in the mid-field until the call of time, and, as the scores were even, an extra ten minutes each way was ordered. During the first of these Guy's pressed continuously, and O'Brien, with a fine kick, dropped what appeared to be a goal, but the wind just caught the ball and spoiled his effort. During the last ten minntes, play was very keen on both sides, but our forwards were beginning to feel the effects of playing one short, and Surbiton, attacking hotly, secured a try through the agency of Williams, from which Jupp kicked a goal. Guy's, with only a few minutes to go, opened the game up on the off chance of scoring, but the manœuvre suited the Surbiton backs, Andrews securing another try from which no goal resulted. No side was called immediately, and Guy's lost a keenly-contested game by 1 goal and 2 tries to 1 try. Team:

Guy's.—E. N. Jupp (back); J. H. Wilkes, A. O'Brien, J. Shannon, and F. W. Sime (three-quarters); C. D. Pye-Smith, W. Jarvis (half-backs); R. C. Lawry, G. Shorland, H. S. French, A. R. Thompson, D. P. Watson, B. Milsom, A. Glendinning, and H. V. Bagshawe (forwards).

Association Football.

GUY'S v. ST. BARTHOLOMEW'S.

Inter-Hospital Challenge Cup.—Semi-Final Round.

The above teams met at Richmond, on the Old Deer Park Ground, on Friday, March 3rd, to play off the Semi-Final Round of the Inter-Hospital Cup. Guy's won the toss and played down hill. For the first twenty minutes, play was fairly even, when Guy's broke away and scored through Norton. Soon after the kick-off Dent scored another goal for Guy's, and Marrett scored for Bart.'s.

Soon after, half-time was called, with the score, Guy's 2 goals, Bart.'s 1. After the change of ends, Bart.'s showed up to great advantage and had decidedly the best of the game, scoring 3 goals (O'Brien, Marrett, and Ward). Guy's failing to improve their score, Bart.'s thus qualified to meet London in the Final.

Remarks.—Smith, in goal, was certainly seen at his best, saving in splendid style, and our defeat cannot in any way be attributed to him. Of the backs, Shepherd was the better of the two, Robson appearing to be out of condition. Brydone, at half, was perhaps the most prominent. The forwards never appeared to get together, and of a poor lot Norton was the pick. Hughes, considering he has not played much this year, also played a good game. Team:—

Guy's.—F. M. V. Smith (goal); W. M. Robson, N. P. Shepherd (backs); R. W. B. Hall, H. B. German, J. M. Brydone (halves); H. C. Dent, F. B. Manser, C. Norton, A. Hughes, F. Morris (forwards).

GUY'S 2nd XI. v. OLD FORESTERS 2nd.

This match was played last Saturday at Snaresbrook, on the Old Foresters' ground, and resulted in a win for the Hospital by 3 goals to 1.

Our opponents won the toss and elected to play with the wind at their backs. The play during the first half went in favour of our team, but although several good shots were put in from the left wing, half-time arrived without any score.

On resuming, the Hospital forwards got away, and the Foresters' custodian, partially clearing a shot from Langdale, Camps got to the ball and scored. The home forwards now attacked, and scored through their right wing. This woke our team up, and the ball was once more put through, but the point was not allowed. However, we continued to press, and scored twice more, through Morris and Rust, before the whistle blew. The following are the team:—

E. T. Heap (goal); J. Matthews, R. W. Witcombe (backs); A. H. Smith, J. W. Gromitt, P. P. Cole (halves); P. W. L. Camps, B. Rust, H. M. Langdale, H. Morris, P. A. Peall (forwards).

GUY'S 2ND v. ST. MARY'S 2ND.

INTER-HOSPITAL JUNIOR CUP.

The second round of this competition was played at Wimbledon on Thursday, March 2nd, and Guy's qualified for the final after a hard game, coming out winners by 3 goals to 2.

A late start was made, Guy's starting against sun and a slight wind. The play was for some minutes in midfield, when Mary's made several sharp attacks, but the shooting was bad. Guy's were playing a very slack game, and conceded several corners, from which, however, nothing resulted. A little combination among the forwards enabled us to press for short periods, but during the first half Mary's had the best of the game, and scored shortly before half-time from a good shot by Graham.

On restarting, Guy's played a completely different game, rushing the ball down time after time, and Roberts soon scored for us. Mary's, however, worked hard, and being awarded a free kick close to our goal, regained the lead with a somewhat lucky shot. Guy's still infused a lot of vigour into the work, and the opposing goalkeeper was kept busy. From a good rush on the right wing and a high centre, Peall headed a beautiful goal. Shortly after this, Roberts was badly hurt, and was of little further use during the game. Guy's, however, kept up the pressure, and scored the winning goal by a fine, low shot from Peall. Mary's tried hard to equalize, and their inside left once got through, but was pulled up just in front of goal. Nothing further resulted, and the game ended as stated above.

Heap, in goal, played a thoroughly good game. Matthews played a good game at back. Cole and Smith were rather out of form at half. Peall was the best of the forwards. Team :—

GUY'S.—E. T. Heap (goal); J. Matthews, V. C. Bent (backs); P. P. Cole, D. G. Greenfield, A. H. Smith (halves); B. Rust, H. K. Lacey, W. O. Roberts, C. T. Hilton, P. A. Peall (forwards).

Appointments.

CIVIL.

BLATHERWICK, H., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer to the Dulwich Sanitary District, Parish of St. Giles, Camberwell.

BRODRICK, C. C., L.R.C.P., L.R.C.S. Edin., has been re-appointed Medical Officer of Health by the Tavistock Urban District Council.

FULLER, W. A., L.R.C.P. Lond., M.R.C.S., has been appointed Senior House-Surgeon to the East Sussex and St. Leonards Hospital, Hastings, *vice* C. R. Nicholson, L.R.C.P. Lond., M.R.C.S., resigned.

TAYLOR, E. C., M.D. Lond., F.R.C.S., L.R.C.P. Lond., has been appointed Medical Officer for the Workhouse, Parish of St. John, Hampstead.

WAKEFIELD, C. F. L.R.C.P. Lond., M.R.C.S., has been appointed Public Vaccinator for the Second and Fourth Districts of the Reigate Union.

NAVAL AND MILITARY.

Surgeon LAWRENCE BIDWELL, R.N., has been appointed to the *Edgar*.

Captain HARRY ST. GEORGE S. HORE, Royal Army Medical Corps, is promoted to be Major. Surgeons on probation, HAROLD PERCY WALLER BARROW, HARRY DIXON PACKER, and LAWRENCE HUMPHRY, are appointed Lieutenants, Royal Army Medical Corps.

Major E. H. MARKER and Captain G. T. RAWNSLEY, Royal Army Medical Corps, are posted to Madras and the Punjab, respectively.

Surgeon-Major C. C. BRODRICK, Volunteer Battalion of the Devonshire Regiment, resigns his commission.

Surgeon CYRIL SHEPHERD, R.N., has been appointed to the *Vivid*, for disposal.

Surgeon-General H. S. MUIR, M.D., has been appointed Deputy-Director General, *vice* Surgeon-General W. Taylor, M.D., C.B., who has vacated that appointment. Surgeon-General Muir entered the Service in 1864, and served through the Afghan War of 1878–80, receiving the medal for the Campaign.

Surgeon-Lieutenant J. W. PARE, M.D., 17th (North) Middlesex Rifles, is promoted to be Surgeon-Captain.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

Birth.

CAMPBELL.—On February 18th, at Eldon Royd, Bradford, the wife of H. J. Campbell, M.D., F.R.C.P., of a daughter.

Marriages.

PEDLEY—WOLSEY.—On March 1st, at Denmark Place Baptist Chapel, Samuel Edward Pedley, L.R.C.P. Lond., M.R.C.S., L.D.S., of Camberwell, to Ada Elizabeth, daughter of James Wolsey, of Shelford Lodge, Camberwell.

TYSON—DU-BOULAY.—On February 14th, at St. Paul's, Sandgate, William Joseph Tyson, M.D., of Folkestone, to Lola Haussemayne, youngest daughter of Julius Haussemayne Du-Boulay, Esq., J.P., of West Lawn, Sandgate.

ED.—H. L. E.

Contents.

	PAGE
The Examination of Blood Films with Special Reference to Work on Malaria: by Robert Howard and Walter C. C. Pakes	137-143
Hospital News	144-145
Notices	145
Guy's Hospital Debating Society	146-148
Passim	149-150
Nursing News	150
"The Lass that Loves a Sailor": by G. Sichel	151
Guy's Hospital Dental Society	152-156
In Lighter Vein	156-158
Chapel News	158
University of Cambridge: Easter Examinations	158-159
Appointments	159-160
Sport: Football—Association: Guy's 2nd v. St. Bart.'s 2nd Inter-Hospital Junior Cup (Final Tie)	160
From the Gazette's Special Pathologist	160

Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, Guy's Hospital Gazette, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the Gazette *bound should leave them with the Librarian.*

The annual Subscription to the Gazette *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well a subscriptions, should be sent to the Financial Editor,* Mr. C. H. Wells, Secretary's Office, Guy's Hospital.

The charge for binding in blue, with the Arms of the Hospital in gold will be One Shilling and Sixpence.

Calendar of Coming Events.

April, 1899.

Sat. 8th.—Messrs. Howse and Jacobson's take-in; Drs. A. H. Davies and A. C. Lewis; Cl., F. D. Turner.

Mon. 10.—First M.B. Durham Exam. begins.

Tues. 11.—Third Conjoint Exam. begins.

Second part of the Cambridge D.P.H. Exam. begins.

Wed. 12.—Messrs. Davies-Colley and Symond's take-in; Drs. H. V. Bagshawe and H. A. Higgins; Cl., J. S. Taylor.

Schedules for L.D.S. Eng. to be left at the Medical School Office, with the Certificate of Mechanical Dentistry, signed.

Sat. 15.—1.15 p.m. Clinical lecture by Dr. Perry.

Last day for names to be sent in for Third M.B. Camb.

Mon. 17.—Second M.B. Durham Exam. begins.

Wed. 19.—Messrs. Lucas and Lane's take-in; Drs., J. C. J. Da Silva and J. S. S. Perkins; Cl., J. T. Dunston.

Last day for sending in Fees and Certificates for Third M.B. Camb.

Sat. 22.—1.15 p.m. Clinical lecture by Dr. Perry.

Guy's Hospital Gazette,

APRIL 8, 1899.

The Examination of Blood Films with Special Reference to Work on Malaria.*

By Robert Howard, M.A., B.M., B.Ch. Oxon.

Medical Officer, Universities Mission to Central Africa (Nyassa Diocese),

AND

Walter C. C. Pakes, D.P.H. Camb.

Professor of Hygiene in the Bedford College for Women; Demonstrator of Sanitary Science and Bacteriology at Guy's Hospital.

(From the Bacteriological Laboratory, Guy's Hospital.)

The accounts given in various text books and monographs of the preparation of blood films for microscopic examination are by no means satisfactory. All err in one important respect, viz., they lack detail. Many writers after going so far as to recommend a particular method add a note to the effect that the results obtained are not constant.

Some time ago we had convinced ourselves of the fact that, however excellent the results might have been in the hands of the authors of the various methods, we were certainly unable to obtain satisfactory and constant results, and this in spite of our endeavours to carry out the procedure exactly in accordance with the directions. We therefore set to work to try all the various methods, and also modifications of them, in order to see whether by paying particular attention to detail we could obtain constant results. This we claim to have done, and after giving an account of our work we shall summarise our results and point out the details which are necessary to ensure success.

The blood may be examined either in the fresh state or in stained preparations. The former is undoubtedly the most satisfactory method for diagnosing malaria, the latter for examining in such conditions as leucocythæmia.

The blood is generally collected from the lobe of the ear or from the back of the distal phalanx of a finger. Each of these places has its advantages. The lobe of the ear is certainly the most convenient when several large drops are required, as for Widal's reaction, and for the bacteriological examination of the blood, because the ear is more easily rendered aseptic than the finger. It is also an advantage when nervous people are being dealt with, as they cannot see what is being done. The painlessness of the prick is a great advantage when children are the subjects. The finger, on the other hand, is more convenient for the operator, and if a really sharp instrument is used the pain is very slight.

The skin should be cleaned with soap and water or alcohol, and then rubbed dry with a cloth. For bacteriological examination where strict asepsis is necessary it should be washed with lysol (2 per cent.) or carbolic acid (2½ per cent.), and then with alcohol and ether, equal parts, which is allowed to dry off, or else is wiped off with a pad of sterilised cotton wool.

* Reprinted from the *Journal of Tropical Medicine*, Feb. 15th, 1899.

The ease with which the blood is collected depends to a large extent upon the suitability of the instrument used to prick the skin. An ordinary sewing needle is practically useless. Surgical needles are fairly good provided they are sharp, but it is difficult to obtain many drops of blood from one prick. A lancet is the best instrument, because it is sharp and makes a minute linear incision. It has, however, two disadvantages: firstly, it is not easy or suitable for sterilising; and secondly, many patients, and especially neurotic ones, will raise objections to its use, since they imagine that it cannot be used without cutting. In order to obviate this difficulty one of us (Pakes) has contrived an instrument which has the advantages of the lancet without its disadvantages. A full-sized hare-lip pin is cut off at the broadest part of the lance head, and the end is then sharpened from the point to the shoulder.

This, then, becomes practically the end of a lancet mounted on a pin. It can be easily sterilised by passing through the flame or boiling, and it does not differ much in appearance from an ordinary long needle.

The coverslips and slides which are to be used must be scrupulously clean. As they are bought, they are by no means clean as the word should be understood when working with blood. They are covered with organic matter, and often with grease from the packer's hands, &c. There are two or three ways of cleaning them. Cabot[1] suggests that both slides and coverslips should be washed well in soap and water, then in water, and subsequently dried and polished with a clean handkerchief. This is a very satisfactory method for the slides, but the percentage of breakages in the case of coverslips is apt to be great, especially as the thinnest, *i.e.*, No. 1, have to be used, in order to admit of subsequent examination with an oil immersion lens. The method we adopt for the coverslips is to drop them one by one into a 10 per cent. solution of chromic acid, contained in an enamelled iron dish, and boil them for twenty minutes. They are then tipped altogether into a shallow basin and washed with ordinary tap-water until all trace of the yellow colour of chromic acid has disappeared. The water is next poured off and the slips are covered with rectified spirit. After this they are washed in absolute alcohol, and transferred with clean forceps to a glass-stoppered, wide-mouthed, shallow bottle containing absolute alcohol. One to two or more ounces may be cleaned at the same time. As they are required for use they are picked out of the bottle singly with forceps; the alcohol is allowed to drain off for a second or two, and the remainder is burnt off by just passing the slip through the flame of a spirit lamp or Bunsen's burner.

We were struck with the fact that when we were preparing fresh specimens of the blood we could not obtain such good preparations with the slips cleaned as above as with those cleaned by Cabot's method.

After trying a few experiments we satisfied ourselves that the mechanical polishing was the great factor in success, and we found that coverslips cleaned as above with chromic acid, and then polished by rubbing with a clean handkerchief for a few seconds, after the alcohol had been burnt off, gave as good results as when cleaned with soap and water. As in the method we employ, a large number of coverslips can be cleaned once for all and then kept in absolute alcohol till required, it will be seen that it is less laborious than cleaning them individually each time.

In preparing fresh specimens the following points must be observed. It is best to employ $\frac{3}{4}$ inch square coverslips and the usual slides 3 inch by 1 inch. The drop of blood should be of medium size; if it is too large, too much will be taken up by the coverslip; if it is too small the coverslip is likely to touch the skin and pick up dirt and grease. Hence if blood flows freely from the prick the first few large drops must be wiped away, while if the drop is too minute gentle pressure should be used to increase its size. Hold the coverslip (cleaned and polished as above) by two of the diagonally opposite corners between the thumb and middle finger and place the index finger on the anterior corner; it is thus fixed by three points of the square and can be firmly held. Lower the coverslip till its centre just touches the extreme top of the drop of blood and then drop it, blood surface downwards, on to the slide, taking care to keep the surfaces of slip and slide parallel.

Another and perhaps easier method is as follows. Holding the coverslip in forceps, lower it till it touches the drop of blood as above, but then place it on the table, blood surface upwards, and lower the slide on to it. The blood at once begins to spread out and the slip adheres to the slide, thus allowing the latter to be rapidly turned over.

If slide and coverslip are clean no pressure is required to obtain a thin film, and pressure should be avoided because it leads to vacuolation of the red discs and also to the escape of intra-corpuscular parasites.

As soon as the film has spread out it should be ringed round with vaseline or cedar oil to prevent evaporation. For a description of the naked-eye and microscopic appearances of fresh blood films we cannot do better than refer the reader to the excellent account of Manson.[2]

When films are to be prepared for staining it is no less necessary that the surface upon which the blood is to be spread must be scrupulously clean, but coverslips which have been cleaned with chromic acid may be taken out of the absolute alcohol and used as soon as the latter has been burnt off; no polishing is necessary in this case. The surface must not be touched with the fingers as where there is any suspicion of grease the blood may miss the greasy portion and be collected in masses at the edge, or while apparently evenly distributed, on microscopic examination the discs may be found to be collected in little groups interspersed with clear areas.

1 A Guide to the Clinical Examination of the Blood for Diagnostic Purposes, R. C. Cabot, M.D.; Second Edition, Longmans, Green and Co., 1897, p. 7.

2 "Tropical Diseases," P. Manson, M.D., First Edition, p. 22. etc.

The method of preparing blood films usually described in the text books is known as the "two coverslip" method. A drop of blood is collected on one slip and a second slip is generally dropped upon it so that the two form a star with eight points. When the blood has spread out between these they are separated by drawing one over the other. The chief advantages claimed for this method are its extreme simplicity and that it requires no apparatus. The disadvantages are unfortunately very soon discovered. If too little blood has been collected it is extremely difficult to separate the slips without breaking one or other of them. If too much, the film is too thick and the corpuscles are crenated; even if the right quantity has been collected the majority of the blood is apt to collect at the edges or in ridges. The explanation of this last phenomenon is, we think, that it is very difficult to keep the coverslips parallel when drawing them apart. Fairly good films are only made by good manipulators and then only after long practice. Cabot[3] admits that even in his hands the uppermost of the two films is never so good as the lower one.

Manson[4] has recommended that the films should be made by collecting the blood on the edge of a piece of thin gutta-percha tissue or tissue-paper, and drawing it along the surface of a slide. We have tried this repeatedly, and are convinced that after a very little practice a tyro can obtain very fair specimens, certainly much better than he could hope to obtain with the two coverslip method without endless practice.

There are three objections to using slides. Firstly, they are much more likely to collect dirt and grease. Secondly, they are very much less handy than coverslips during the process of staining. The third and perhaps greatest objection is that being so bulky they are very much more inconvenient to pack, carry about, or transmit through the post. This is a great consideration for anyone who is studying, say in Africa or India, and is some distance from the laboratory.

Fair films may be made by applying Manson's method to ordinary-sized coverslips, but it is difficult to gauge the amount of blood requisite to cover so small an area. We, therefore, tried arranging three or four coverslips in line, and fixing them by means of a specially contrived clip,[5] and then drawing the paper over all four slips at once. We found, however, that the blood tended to run down into the cracks between the slips, and further that the first slip was too thickly and the last too thinly spread. We therefore tried specially long coverslips $1\frac{1}{2}$ in. by $\frac{3}{4}$ in. On these we found we could make excellent films, quite as good as on a slide. In fact, as it is only the middle half of a slide that is used, whereas the whole surface of a coverslip can be covered, the size of the films is practically the same. The clip was adapted so as to hold four of the long coverslips securely fixed by their extreme ends, and we have found it a great convenience If it is not used the end of each slip must be held down with the finger or forceps while the film is being spread.

If a large number of specimens is wanted the coverslips may be scratched with a diamond and broken across, thus giving two $\frac{3}{4}$-in. square. For diagnostic purposes, however, especially in cases of malaria, the long film is an advantage, as a considerable quantity of blood can be examined in one specimen and it is easy to arrange that the upper end shall be rather thickly spread and the lower quite thinly. By this method we claim to have combined all the advantages of Manson's slide-method with the use of the coverslip.

As regards the tissue used, we have not been successful with gutta-percha tissue, and so have discarded it. We have tried various kinds of tissue paper and have finally accepted cigarette paper as the most convenient. There are two small points to be noticed. Firstly, the edge used must be the original machine-cut edge; and secondly, it must be that which is parallel to the ribs. The best papers are the Tarlene, or the Zigzag, not the familiar A. G. papers. Strips are cut across the ribs so that each is about half an inch wide and as long as the original cigarette paper is wide. Should cigarette papers not be at hand, ordinary note paper may be used, but it is not nearly so good.

In making the film the strip is held between the thumb and first finger and is lowered till the under surface adjacent to the machine-cut edge just touches the drop of blood as it rests on the skin, and then by a slight lateral movement the drop is converted in a streak. This end of the strip is at once laid blood downwards on one end of the coverslip, the other end being still held, and the blood having been allowed to spread out between the paper and the coverslip, the paper is slowly drawn along the slip towards the other end. A fresh strip of paper should be used for each film.

The size of the drop of blood is of importance. With a normal patient a few films are sufficient to enable the observer to gauge the correct amount. When the patient has great diminution in red corpuscles and the blood is correspondingly watery, a larger drop must be taken as if a much thicker film were intended, the increase in size being proportional to the degree of the anæmia. If this point is not attended to the discs will be found to be somewhat widely scattered, and hence the films will be somewhat more tedious to examine.

After the films are made they are allowed to dry in the air. This only takes a few seconds if they are thin and even. They may then be packed together by placing coverslips and small pieces of clean paper alternately. During this process the coverslips should be held in forceps, not with the fingers, for until the film is fixed it must not be brought into contact with any moist surface, or the red discs will be destroyed and the blood laked. If kept dry the films will keep any length of time,

[3] *Op. cit.*, p. 32.

[4] *Op. cit.*, p. 30.

[5] This clip, devised by one of us (W.C.C.P), consists of a light block of wood on which the slips are held by the pressure of a brass spring. It was exhibited at a meeting of the Pathological Society on December 20th, 1898. It can be obtained from Messrs. Watson & Son, 313, High Holborn. Price 3s.

but in very damp climates, as in Africa, it might be advisable to fix them before sending them home.

Arrived at the laboratory, the next procedure is to fix the films. The fixing agents we have tried are heat, alcohol, alcohol and ether, corrosive sublimate, osmic acid vapour and formalin.

Heat is perhaps the best fixing agent, as it can be used for every purpose. The optimum conditions are a temperature of 115° C. for two hours. The special advantage is that the granules are preserved better than by any other method. The disadvantages are that it necessitates a regulated hot-air oven, and is not so quick as some other methods. The oven method is no disadvantage in a well equipped laboratory, but few medical men have room or sufficient use for one.

Cabot[6] suggests the following as a substitute for an oven. A strip of copper 3 × 12 in. supported over a flame very soon gets a constant temperature at any given distance from the flame. On this, find the boiling point of water by dropping small drops of water on it, and put the cover glasses at this point face downwards.

A mixture of equal parts of absolute alcohol and ether for half an hour or longer also fixes the films well. Next to heat it is the best for preserving the granules, and it gives the corpuscles a clear, distinct outline.

Immersion in absolute alcohol for from ten minutes to half an hour gives very good fixation as far as red discs and intra-corpuscular parasites are concerned, but it is less good for the granules in the leucocytes. For malaria, however, with certain stains, it is excellent.

For work in tropical countries the two last, being volatile, are somewhat difficult to deal with. The method we have adopted will get over the difficulty to some extent. The alcohol or alcohol-ether is placed in a Petri dish (*i.e.*, a shallow glass dish, with overlapping glass cover, usually termed in the bacteriological laboratory a "plate") about 2½-in. diameter and covered over with its proper lid. The evaporation and hydration which take place are very small, and we have found that we can effectually fix films in fluids which have been in the Petri dish for two or three days in a warm laboratory. In the tropics it would be better after use to pour the alcohol back into a bottle kept for the purpose.

We thought that it might be possible to replace these volatile fixing re-agents by a saturated aqueous solution of corrosive sublimate. This only requires five minutes for thorough fixation of the film, but it has the disadvantage that it destroys the granules and limits the number of stains that can be used. Before staining a film fixed in this manner, it must be well washed in water, treated for a few seconds with Gram's iodine solution (*i.e.* liq. iodi. one part, water fifteen parts), then with alcohol (methylated spirit will do) for two or three minutes; otherwise crystals of corrosive sublimate are left on the film. Should the supply of absolute alcohol run short, corrosive sublimate could always be obtained, and this method may then be used with advantage.

[6] *Op. cit.*, p. 33.

The vapour of osmic acid fixes the films as well as any of the above reagents, but it restricts the stains within very narrow limits.

It may be mentioned by way of caution that in all blood films, but especially after fixation with corrosive sublimate or osmic acid, little groups of blood platelets which take a basic stain may be found. These have often been called sporulating parasites; but if the observer is alive to the danger, a very little practice will prevent any mistake as to their identity.

After the film has been fixed it becomes necessary to stain it. The best known blood-stain is the Ehrlich-Biondi triple stain. Many modifications of this have been made, and many are the receipts given in the text books for making them up from the constituent elements. It is simpler and more satisfactory to use the Ehrlich-Biondi-Heidenhain powder which is supplied by Grübler. We have employed this made up according to Cabot's directions,[7] *i.e.* Ehrlich-Biondi-Heidenhain powder gr. xv. (*i.e.*. one gram approximately), absolute alcohol 1 cc., water 6 cc., and also as recommended on the label by Grübler. Of the two we prefer Cabot's mixture, which, although a very strong solution, is easy and convenient to work. The stain is dropped on to the coverslip with a glass rod or pipette and after five minutes washed off with water. This is generally admitted to be the most satisfactory distinctive stain for the leucocytes and their granules, but it entirely fails to stain the malaria parasite.

Another well-known combination and one which is specially recommended for malaria is that of eosin with methylene blue. It is in the details of this method, however, that the text books are most meagre. One is recommended to make up solutions of certain strengths of "eosin" and methylene blue. Grübler[8] (whose laboratory is the recognised source of pure histological stains) supplies no less than four different eosins. These are (1) aqueous eosin, "yellowish"; (2) aqueous eosin, "bluish"; (3) blood eosin; and (4) alcoholic eosin. Of these, the first three are readily soluble in water or alcohol, the fourth is practically insoluble in water, but fairly soluble in from 60 per cent. to absolute alcohol. All these readily stain the red discs, but they differ in that the first three—whether alcohol or water is used as the solvent—are much more easily removed by subsequent manipulation than the alcoholic stain, which is most persistently retained. There is less difficulty about the methylene blue, since Grübler only supplied one variety of this stain.

Besides the above there is also a number of commercial varieties of both stains, which, however, are unsuitable for histological purposes.

Of these two stains eosin is strongly "acid," having a special affinity for hæmoglobin and eosinophile granules; methylene blue is "basic" and stains the nuclei. They are, moreover, direct antagonists, for if either stain is in

[7] *Op. cit.*, p. 33.

[8] Grubler's stains may be obtained from Messrs. Baird & Tatlock, Cross Street, Hatton Garden, E.C., or from C. Baker, 244, High Holborn, W.C.

excess in a mixture, or when used as a consecutive stain, s allowed to act for a sufficiently long time, it will completely turn out the other. It must be stated, however, that eosin turns out methylene blue much more readily than methylene blue turns out eosin. Recognising this principle of antagonism, various attempts have been made to produce mixtures in which the two stains shall be exactly balanced, with the idea that each will then stain its appropriate element. Among the commonly described mixtures are Plehn's, Romanovsky's, Thayer's modification of Romanovsky's, and Geppener's.[9] Each of these is recommended by its respective author as specially applicable to work on malaria.

However ideal such an arrangement may be, and however satisfactory in skilled hands, there are factors in the manipulation which are not easy to determine and which render these mixtures—as their various authors allow—uncertain. We are quite prepared to admit that when plenty of material is available, and when one is dealing with undoubtedly malarial blood, these mixtures may be useful for studying the various phases of the different parasites, but their uncertainty enders them unsatisfactory, perhaps almost dangerous, for diagnostic purposes.

Our non-success with these mixtures cannot be attributed to the fact that we have used the wrong eosin, for we have tried to make up the mixtures with each of the four kinds. For instance, in endeavouring to make up Plehn's solution, we found that if alcoholic eosin were used it completely precipitated on the addition of the water and the films stained with methylene blue: if we use aqueous eosin our films usually stained only with eosin. That we were alive to the fallacies of the eosin is shown by the fact that we did not abandon this stain until we had made eight different attempts to prepare it. It is possible that this mixture may work well if it is kept for a long time before use. No such suggestion, however, could be found by us in any description.

Similar unsatisfactory results were obtained with the other mixtures, though with these it was sometimes the eosin and at other times the methylene blue which predominated.

Quite apart from the staining powers of these mixtures there remains the objection that, as most of them formed copious precipitates owing to the interaction of the stains, and as this precipitate, according to the instructions usually given, must not be filtered off, the films are apt to be obscured by precipitated stains which cannot be washed off.

For work in the tropics there is the further, and we consider greater objection, that the mixtures will not keep, but must be made up practically every time that they have to be used, and the excess stain is wasted, whereas if single stains are employed they can be poured back and used again. This is no slight consideration when the supply of reagents is limited.

[9] For references see "Lectures on the Malarial Fevers." By W. S. Thayer, M.D. Henry Kimpton. 1898. Pp. 40 *et seq.*

For work with non-malarial blood where the staining of the leucocytes rather than of the red discs is of importance, the mixtures are not attended with such drawbacks, and they undoubtedly may stain the granules very clearly. There is one mixture we have got to give fairly satisfactory results, and this is:—equal parts of one per cent. aqueous sclution of aqueous "yellowish" eosin, and saturated aqueous solution of methylene blue, diluted with five volumes of water and filtered. This is a modification of the one suggested by Ramsden (Guy's Hospital Gazette, vol. x., p. 149) and is the same as that which Thayer recommends, but diluted and filtered.

Having discarded the mixtures we next endeavoured to find whether any single stains would give satisfactory results. We began with methylene blue, which we knew to be a good basic stain.[10] This stain can be used after any method of fixing, but its effect varies greatly with the solvent. When dissolved in distilled water, or in ordinary tap water, unless the latter is very distinctly alkaline, it acts as a pure basic stain, *i.e.*, the nuclei of the leucocytes and malaria parasites are stained blue, while the red disc show distinctly of their natural pale yellow colour. The pale discs, when properly fixed, are quite distinct, and at the same time extremely transparent, so that the intra-corpuscular parasites stand out well. This transparency of the discs may be taken advantage of when the films, either from accident or design, are thick. When pigmented parasites or crescents are being dealt with, and they are few in number, they can be more easily found in thick films stained in this method than in thin double-stained films. This stain should be used in saturated solution. A certain quantity ($2\frac{1}{2}$ grams to each 100 cc. of water, is ample) of the dry stain should be placed in a bottle to be used as the stock bottle, and the bottle filled with water. This should be left for at least a week, and should be shaken up from time to time. After the lapse of this time the supernatant fluid should be filtered into a smaller bottle, while so long as undissolved stain is left at the bottom fresh water may be added to the stock bottle. In order to prevent the growth of moulds, &c., in the solution, 1 cc. of a 10 per cent. solution of formalin in water may be added to each 100 cc. of stain. We have found that this does not in any way affect the staining power. It is impossible to overstain with this stain, but it is not necessary to stain for more than five minutes.

Several other solutions of methylene blue are commonly prepared with the object of obtaining a more rapid and deeper stain. Among these may be mentioned carbolic methylene blue, Löffler's methylene blue and borax methylene blue.

The two latter stain very rapidly (half to one minute) but the discs are coloured an opaque blue and hence the contrast between discs on the one hand, and leucocytes

[10] The method of staining and mounting which we have adopted throughout is as follows:—A little stain is poured into a Petri dish, and the coverslip floated on it film downwards; it is then removed with forceps. washed in tap water, dried between layers of clean filter paper, and then over a flame, and finally mounted in Canada balsam.

and parasites on the other is less marked. Carbolic methylene blue causes the discs to become granular and vacuolated. For these reasons we cannot recommend them.

Ehrlich's acid hæmatoxylin is another widely used basic stain. If employed for blood films the best methods of fixing are heat or corrosive sublimate. It is of little use in malaria work, because, firstly, it does not stain the parasites at all well; and secondly, it is very apt to precipitate and must be filtered each time it is used. Moreover, the film must be extremely well fixed, otherwise being strongly acid it has a tendency to dissolve the hæmoglobin out of the discs.

At the suggestion of Dr. Alfred McConkey we have tried carbol thionin blue[11] as a malarial stain. He had previously found that it was an excellent contrast stain for blood, staining the discs a pale grey and the nuclei of the leucocytes red. We have found that it will stain after every method of fixation, but after corrosive sublimate the discs are very dark and hence the contrast is less good. It stains the parasites of malaria well, and this is true even of the young forms. To obtain the maximum contrast the films should be left in the stain for three minutes. Its only disadvantage is that it does not stain the granules in the leucocytes, and this cannot be remedied by combining it with eosin. It has a tendency to form a crystalline precipitate and it may be necessary, therefore, to filter the stain from time to time. It may be remarked in passing that it is an excellent stain for showing blood discs in sections of inflamed tissues. In aqueous solution thionin blue only stains the nuclei, leaving the discs quite unstained.

Our next endeavour was to try various consecutive stains and study the conditions necessary for success with them.

As we have before stated, Ehrlich's hæmatoxylin does not stain the hæmatozoon of malaria at all well, and therefore this, followed by eosin, is only to be recommended for non-malarial blood. If this sequence is used the procedure is as follows:—Fix by heat or corrosive sublimate; stain three minutes in hæmatoxylin; wash well in tap water; and then stain for half a minute with a 1 per cent. solution of any of the aqueous eosins. These two stains have not the antagonistic properties possessed by methylene blue and eosin, and hence fair results are easily obtained.

As above mentioned, eosin turns out methylene blue far more rapidly than methylene blue decolourises eosin. Hence when these two stains are employed in a consecutive method it is always necessary to stain first with eosin and then take methylene blue. In order to obtain uniformly satisfactory results with the methods here described the times laid down must be carefully adhered to.

[11] In Muir & Ritchie's "Bacteriology" the receipt is given as follows:—Thionin blue, 1 gram; 1 in 40 aqueous solution of carbolic acid, 100 cc. It is recommended for staining bacteria. (Thionin blue is obtainable from Grübler or his agents.)

The various eosins resolve themselves into two groups, of which the three aqueous varieties form one and the alcoholic another. The members of the aqueous group are fairly readily decolourised by an aqueous solution of methylene blue, whereas the alcoholic variety, being almost insoluble in water, resists its action for a long time. Hence the necessary procedure varies considerably according to which kind is used.

In like manner the kind of methylene blue solution is of importance. In fact, saturated aqueous methylene blue is the only one which can be used as a consecutive stain to eosin, since Löffler's and borax methylene blue both tinge the red discs, thus rendering them an opaque purple, which effectually obscures the parasites.

When aqueous eosin is to be used the films may be fixed with heat, alcohol-ether, or alcohol. The two former are best when it is desired to retain and examine the granules in the leucocytes. For malarial parasites alcohol is fully as good and of course simpler. With alcoholic eosin alcohol is rather less satisfactory than heat or alcohol-ether because the ground work has a tendency to take the eosin stain. The alcoholic eosin is the only form of eosin which can be satisfactorily employed after fixing with corrosive sublimate, as the aqueous varieties do not give the discs a sufficiently intense colour. After fixation by osmic acid vapour the red discs cannot be stained with any kind of eosin.

When staining with aqueous eosin we employ 1 per cent. aqueous solution, to which 10 per cent. of alcohol may be added to make it keep better. The films should be left in this solution for thirty seconds; they should then be washed in water and left in the aqueous methylene blue for not less than three minutes and not more than five minutes. The resulting preparation under the microscope shows the nuclei of the cells and the parasites coloured blue and the discs a pinkish yellow. There is no great difference between the three watery eosins, but we prefer the "yellowish" or "bluish" to the "blood" because they give a more intense colour to the discs. If the films be left much more than five minutes in the methylene blue it will be found that the red discs have been decolourised, and the specimens are hardly to be distinguished from those stained simply with methylene blue.

For alcoholic eosin the procedure is as follows:—Stain thirty seconds in a ·5 per cent. solution in 60 per cent. alcohol (this is practically a saturated solution), wash in water and stain with methylene blue for about thirty minutes. The long time which the methylene blue requires to act depends upon the difficulty with which it replaces the alcoholic eosin in the neuclei of the cells and the parasites. The difference between these preparations and those stained with aqueous eosin lies chiefly in the fact that the discs are distinctly red and more opaque, so that the contrast with the blue is more marked.

A new consecutive method, which combines fixing and staining, has recently been described by Wermel.[12] The

[12] *Medizinskoje Obosrenje* (Russ.), May, 1897.

film without previous fixing is placed for two minutes in a 5 per cent. solution of aqueous eosin in 50 per cent. alcohol, containing 2 per cent. of formalin. It is then washed and placed for a similar time in aqueous methylene blue also containing 2 per cent. of formalin. We find that it fixes and stains the leucocytes excellently, but the result of the formalin is to make the discs granular and it is therefore totally unsuited for work on malaria.

We have tried several stains in the place of eosin, such as vesuvin, aurantia, saffranin, &c., but we could not find that they possessed any special advantages, whereas they all had the great disadvantage that they would not stain the granules in the leucocytes. Acid fuchsin, though it stained the granules, had the great disadvantages that the depth of colour imparted to the discs varies greatly with the time during which it is allowed to act, and that it was readily turned out by methylene blue.

In drawing our conclusions we do so from the examination of upwards of a thousand stained films, of which more than two hundred were of malarial blood. What we have said about the malarial parasites refers chiefly to the tertian and quartan varieties, for unfortunately we have not been able to obtain many specimens of young malignant parasites. We conclude, however, that since we have succeeded in obtaining good and constant results with quite young tertian and quartan hæmatozoa, we could have obtained equally good results with the malignant ones, and the few specimens which we have examined bears out this conclusion. We regret also that we have been unable up to the present to work out the staining reactions of the flagellate bodies.

We are convinced that by working on properly cleaned coverslips instead of on slides, the resulting specimens are freer from dust and precipitated stains, and thus freer from many of the fallacies against which warning is often given in the text books.

If both fixing reagents and staining fluids are kept as recommended above, in Petri dishes, contamination of the films may be almost entirely avoided.

We have felt that the blood platelets which are often seen, especially after fixing with corrosive sublimate, might easily lead to error, and we find that Thayer says that this has actually happened. The advisability of carefully examining normal blood, both in fresh films and stained by the various methods advised, cannot be too strongly urged upon all who are not experts in blood work.

The following is a brief summary of the procedure which we recommend :—

(*a*) When blood does not contain malaria parasites;
  (1) Fixing by heat and staining with (*a*) Ehrlich-Biondi or (*b*) aqueous eosin followed by aqueous methylene blue, or (*c*) alcoholic eosin also followed by aqueous methylene blue; or
  (2) If heat be unavailable fixing with alcohol-ether and staining as above.

(*b*) When malaria parasites are to be sought for;
  (*α*) Single stains.
    (1) Aqueous methylene blue after any fixing agent.
    (2) Carbol thionin blue after any fixing agent except corrosive sublimate.
  (*β*) Consecutive stains.
    (1) Fixing by heat or alcohol and staining with aqueous eosin, followed by aqueous methylene blue.
    (2) Fixing by heat or alcohol-ether and staining with alcohol eosin, followed by aqueous methylene blue.

At the suggestion of one of us who is shortly to proceed to Central Africa, Mr. C. Baker, of High Holborn, has supplied a Ross diagnostic microscope, with the case adapted so as to hold, in addition to the microscope and two objectives, all the above-mentioned necessaries for blood examination, viz., spirit lamp, glass bottle to hold coverslips kept in absolute alcohol, glass tube to hold three of Pakes' special pins kept in alcohol to prevent rusting, coverslip clip, tin box in which to pack coverslips after the films have been made, forceps, slides, vaseline and cedar oil. The whole outfit weighs only 4 lbs. and measures 11 inches by 3½ inches by 3 inches; it contains everything requisite for the immediate examination of fresh films and for obtaining dry films for subsequent investigation.

If the method of fixing and staining recommended in this paper be adopted, the following reagents and stains will be required:—Absolute alcohol, xylol, Canada balsam, immersion oil, formalin, chromic acid, half dozen Petri dishes about 2½ inches in diameter, spare forceps, filter paper,[13] cigarette paper, slides and coverslips (¾ inch squares and 1½ inch by ¾ inch). It would be best to take out the latter ready cleaned, packed in stoppered bottles in absolute alcohol. Corrosive sublimate, carbolic acid, vaseline, liq. iodi. and methylated spirit would be found in the ordinary stores of any medical man.

In enumerating the stains approximate quantities are given in order to indicate the rate at which they are likely to be used; the amounts here stated should suffice for one or two years' work. Methylene blue 20 grams, thionin blue 5 grams, aqueous eosin "yellowish" or "bluish" 10 grams, alcoholic eosin 5 grams, and (if work on non-malarial blood is intended) Ehrlich-Biondi 10 grams.

A considerable number of the malarial blood films examined for the purposes of this paper were obtained by one of us at the Branch Seaman's Hospital, Royal Albert Docks. We wish to offer our best thanks to Dr. Manson for the opportunity thus afforded us and to testify to the unfailing courtesy and consideration which we have experienced at the hands of the resident staff of the hospital.

[13] We have found that the best filter paper for this purpose is that supplied by Baird & Tatlock as "German lined."

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Pye-Smith.

Mary 25. Epilepsy.
26. Multiple papillomata of ovaries. Secondary ascites.
29. Mitral stenosis and regurgitation.
36. Functional paraplegia.

Philip 22. Rheumatism. Pericarditis with effusion.
27. Double otorrhœa.
28. Carcinoma ventriculi. Operation.
30. Lupus.
39. Lobar pneumonia.

Cases under Dr. Taylor.

Mary 39. Pleurisy with effusion. Aspirated.
42. Carcinoma of stomach. Vomiting.
43. Jaundice. Growth or gall stones.
44. Gumma of liver.
45. Mitral stenosis. Peripheral embolism.
Cot 55. Œdema and redness of legs. Erythema and desquamation on body. No albuminuria.

Stephen 2. Rheumatism. Recent aortic regurgitation.
3. Pneumothorax.
4. Rheumatism. Aortic and mitral regurgitation.
11. Paralysis agitans.
12. Bronchitis and emphysema.
14. Congenital heart disease.
15. Æt. 7. Broncho-pneumonia clearing up. Persistent high temperature. Old caries of spine.
16. Abdominal tumour.
18. Old empyema. Lardaceous disease. Resection of ribs.

Cases under Dr. Hale White.

Philip 2, 6. Acute rheumatism.
3. Mitral regurgitation and stenosis. Tricuspid regurgitation.
7. Gall stones. Simple infective cholangitis.
9. Chorea.
13. Pancreatic cyst.
14. Sub-acute tubal nephritis.
18. Nephritis.
20. Aortic stenosis and regurgitation.

Mary 13. Phthisis. Glands. ? Tuberculous. Pigmentation. ? Arsenic.
15. Mitral Stenosis and regurgitation. Tricuspid regurgitation.
16. Left pleuritic effusion. Mitral regurgitation.
17. Relapsing appendicitis.
19. Multiple neuritis.
21. Carcinoma of liver and pylorus.
23. Phthisis.
24. Pneumonia of right base.

Cases under Dr. Pitt.

Mary 1. Phthisis.
3. Rheumatism.
4. Thrombosis of left subclavian vein.
5. Phthisis. Thrombosis of left femoral vein.
8. Phthisis.
10. Bright's disease.

Stephen 21. Tubercular peritonitis.
22. Rheumatism.
25. Pneumonia.
28. Peritonitis.
32. Uræmia.
33. Acute rheumatism.
34. Chorea.
35. Pneumonia.

"Clinical."

John 1. Fibroid lung. Ascites.
4. Empyema.
8. Malignant disease of liver.
10. Enteric fever.
12. Pneumonia.
13. Pneumonia.
14. Hemiplegia from cerebral hæmorrhage.
15. Mitral stenosis and incompetence. Hæmoptysis.

Miriam 19. Nephritis: oliguria. Pyrexia.
20. Volvulus: resection. Murphy's button used.
22. Enteric fever.
23. Aneurysm of arch of aorta. Hæmoptysis.
25. Empyema. Resection of rib.
28. Bronchial asthma. Acute.
29. Hydatid of liver. Incised.
30. Acute peritonitis due to pyosalpinx. Operation.
32. Apical pneumonia.
34. Diphtheria. Tracheotomy.
36. Intussusception. Reduced by abdominal section. Convalescent.

In the Surgical Wards.

Cases under Mr. Howse.

Naaman 14. Enlarged prostate.
16. Tuberculous knee.

Dorcas	6.	Tuberculous knee.
	7.	Paralytic bilateral talipes equinus.
	14.	Old hip disease. Furneaux-Jordan's amputation.

Cases under Mr. Davies-Colley.

Job	3.	Irreducible inguinal hernia (omental). Radical cure.
	4.	Talipes equino varus.
	13.	Bilateral gangrene of toes.
Lydia	10.	Tuberculous inferior radio-ulnar joint. Excised.
	11.	Hæmatoma after MacEwen's osteotomy.
	12.	Flexed ankylosed knee after suppurative arthritis.
	17.	Lipoma on shoulder. Excised.
	23.	Supraorbital dermoid. Excised.

Cases under Mr. Lucas.

Lazarus	6.	Spinal caries and gluteal abscess.
	8.	Tuberculosis. Ankle excised.
	9.	Stricture.
	20.	Post-nasal sarcoma.
	23.	Malignant glands in neck, after excision of epithelioma of lower lip.
Martha	3.	Epulis.
	4.	Inflamed incarcerated hernia. Artificial anus formed,
	11.	Fractured femur.
	14.	Gonorrhœal synovitis of knee and ankles.
	15.	Sub-ligamentous patellar bursitis.
	17.	Tuberculous knee.
	22.	Fractured femur.
Cot B.		Retention.
Astley Cooper	4.	Fractured pelvis. Torn urethra.
	14.	Fractured patella.
	28.	Pott.

Cases under Mr. Golding-Bird.

Luke	7.	Irreducible femoral hernia.
	12.	Ununited fracture of tibia and fibula.
	16.	Papilloma nasi.
	17.	Strangulated congenital inguinal hernia.
Charity	1.	Fractured humerus. Lower third.
	3.	Strangulated femoral hernia.
	9.	Gummatous perichondritis of larynx.
	11.	Suprapubic hæmatoma.
	14.	Fractured ribs.
	15.	Ruptured kidney.
	16.	Fractured femur.
Cornelius	1.	Dislocation of lower jaw. Bilateral.
	6.	Fractured femur, left. Compound tibia and fibula, right. Death.
	18.	Cut throat. Laryngotomy.
	18.	Burn from carbolic acid. Death.
Astley Cooper	5.	Burns from carbolic acid.
	19.	Fractured femora.
	18.	Fractured femora.

Cases under Mr. Jacobson (Mr. Fripp acting).

Dorcas	21.	Umbilical hernia. Radical cure.
Patience	14.	Acute infective periostitis of tibia. Total sequestrum removed.

Cases under Mr. Symonds.

Patience	1.	Syphilitic arthritis of knees. Node on forehead.
	16.	Acute mastitis.
Martha	14.	Gastric ulcer.

Cases under Mr. Lane.

Martha	10.	Thyroid cyst. Enucleated.
	11.	Suppurative arthritis of knee.
	12.	Carcinoma mammæ. Excised.
Job	12.	Irreducible inguinal hernia. Radical cure.
	13.	Cystitis. Infantile paralysis.

Cases under Mr. Dunn.

Luke	2.	Malignant glands in neck. ? Primary epithelioma of œsophagus.
	4.	? Infantile hernia.
	15.	Tuberculous cervical glands. ? Syphilitic.
Charity	20.	Tuberculous pyonephrosis.
	Cot.	Tuberculous disease of bursa over great trochanter. Scraped.

Notices.

DEMONSTRATORS OF PRACTICAL DENTISTRY.

Two additional Demonstrators of Practical Dentistry will be appointed for the coming Summer Session. Particulars as to duties and remuneration may be obtained upon application to the Dean. Applications for the post should be sent to the Treasurer, Superintendent's Office, not later than the 14th of April, 1899.

LAURISTON E. SHAW, Dean.

Guy's Hospital, March 17th, 1899.

NAVAL MEDICAL SERVICE.

Medical Department of the Navy,
Admiralty,
Northumberland Avenue, W.C.,
21st March, 1899.

An Examination of Candidates for entry into the Medical Department of the Royal Navy will be held on the 8th May next and following days at Examination Hall, Thames Embankment.

Not less than Fourteen Commissions, as Surgeon, will be offered for competition.

The forms to be filled up by Candidates will be supplied on application to this Department.

H. F. NORBURY, Director-General.

Guy's Hospital Debating Society.

A meeting of the above Society took place on Saturday, March 11th, Dr. Fawcett in the chair, the subject for Debate was—"That this Society deplores the existence of the Halfpenny Newspaper."

Mr. F. G. Gibson said that his topic needed no apology, it appeals to the common sense of everyone. It is not the price of the paper that is objectionable, but its contents, which would be dear at any price. Latter day journalism caters for the most depraved tastes of the least worthy section of readers—it is in fact part of the general literary decadence marked by problem plays and pathological novels. So the cheap newspaper is branded by its disregard of decency, of privacy, of accuracy, of loyalty. In every department of life you may see this—in politics, in the Law Courts, in literature, in the drama, and in sport—and the evil done is incalculable.

Mr. Cazenove thought that the halfpenny paper is for the halfpenny man. This man is the result of School-board education; he has humour and sense, and what he reads is concise and amusing. As for the private life of public men, it is the penalty of their position that they have no private life. The smallest acts show character, and the character of leading men is of legitimate interest to us. The qualities which Mr. Gibson had denounced as disloyalty in politics are more properly to be looked upon as praiseworthy independence. This free and enquiring spirit is brought home to us by the periodic outbreak of hospital scandals, and what can be more stimulating to the student than to know that a slip on his part may make him infamous in almost the next edition. The influence of cheap newspapers may be gauged by the observation that as their circulation has increased, so drink and crime have diminished. Let us then dissociate ourselves from the unctuous hypocrisy which would dictate to a fellow man what motes he may or may not carry in his eye.

Mr. Shufflebotham said that he was suffering from nervousness; nevertheless it was his duty to point out to us the contrast between Mr. Gibson and Mr. Cazenove. The one had appealed to sense, the other to sentimentality. Mr. Gibson's charges were more than true. Certainly price does not ensure respectability, yet refinement and culture cannot be had for a halfpenny.

Mr. Cleveland said that speakers on both sides had been putting the cart before the horse. The halfpenny paper only reflects the taste of the halfpenny public. Thus the fulness of the police-court reports is to be explained by the fact that the class which reads them is also the class which furnishes them. Naturally the working man likes to know if his pal has got fourteen days or a month. From another point of view you may explain facts thus—to read the *Times* takes two hours, to read the headlines of the *Daily Mail* takes a few minutes.

Mr. Thompson said that the live-and-let-live doctrine of Mr. Cazenove is heathenish. Progress demands interference. Before modern journalism the simple love of duty has given place to a hunt for notoriety.

Mr. A. E. H. Pakes said he was sorry to rise so soon, because by speaking later he would have had more victims to criticise. He proceeded to open a deadly fire of small arms against Mr. Gibson, Mr. Shufflebotham, and all their followers, selecting for assault not so much their arguments as their chance phrases and expressions. When the smoke had cleared away, one was relieved to see these two unhappy gentlemen still showing signs of life. It was even thought that they looked little the worse.

Mr. S. Hodgson allowed that halfpenny papers are bad. Still they might be worse. It had been asserted that it takes two hours to read the *Times*. Observations which he had carefully conducted on Mr. F———— enabled him to state positively that the thing can be done in one hour and fifteen minutes. Still the *Times* might be shorter. There are certainly some halfpenny journals of whose morals no right thinking man can approve. Nevertheless Mr. Hodgson had met at the seaside a correspondent of a halfpenny journal who was in every way respectable. The war correspondent had that evening been derided. From his experience as a volunteer, Mr. Hodgson assured us that the correspondent is ever among the bullets. Nevertheless this statement implies no bias, indeed it is hardly to the point, since halfpenny papers do not as a rule employ war correspondents.

Mr. Robinson only spoke for two minutes, but he spoke sense all the time. In answer to the charge that cheap newspapers are cheap and nasty as literature, he replied that they don't pretend to be literature at all.

Mr. Eason was even more compressed. He achieved the soul of wit in a sentence.

Dr. Spriggs admitted that he reads the *Daily Mail*, but pleaded in extenuation that he saves a halfpenny every time; and he is ever on his guard against that superficiality and that spirit of advertisement which are so hateful to the lover of science.

Mr. Goble said we had all missed the point, and the point is money. Metaphorically, but not, alas, in any more substantial sense he brought us to the point.

Mr. Bryan said that its all very well to sit and deplore things. But life is real and life is earnest. What did Mr. Gibson propose to do?

Mr. Cazenove said that at any rate life is brief and so is the halfpenny newspaper. For this he solicited our votes, as well as for its glimpses into things unsavoury, its picturesque and forcible English, and its many perfections and advantages.

Mr. Gibson, in reply to Mr. Bryan, said he proposed to do nothing and go on deploring. He drew a distinction between deploring a thing and being able to remove it. He still maintained that the function of the Press is to amuse, but also to educate.

On a division the motion was lost by 21 votes to 25.

Mr. Fitz-Hugh proposed and the whole company seconded a vote of thanks to Dr. Fawcett. Dr. Fawcett said he would be glad to preside over us again; and we all hope he will.

LADIES' NIGHT.

The Annual Ladies' Night was held on March 25th, when the President, Dr. Pavy was in the chair. Although the weather was unpropitious, and it was the night of the Boat-race, the club smoking-room was packed with members and visitors. Among the latter being a large number of ladies.

The subject under discussion was "That in the opinion of this House, the Tsar's peace proposals should receive the warmest support of the British Government on the grounds of expediency, economy, and the general well-being of mankind."

Mr. L. E. Stamm, in opening the debate, first gave a brief resumé of the Tsar's rescript, and then proceeded to maintain that whereas at first there appeared to be grounds for suspecting the sincerity of Russia in the matter, these had been fully set at rest by the establishment of the fact that the Tsar himself was the sole author of the manifesto. He then dealt with the questions which it had been proposed to discuss at the Conference. These came under three headings: (1) Some agreement not to increase naval and military forces within a fixed period of time, and possibly a reduction of these forces in the future; (2) Efforts to minimise future warfare as far as possible by interdicting certain highly destructive weapons, and by further application and extension of the stipulations of the Geneva Conference in 1864, and of the conference at Brussels in 1874; (3) Acceptation of the principle of arbitration and the establishment of some uniform practice of carrying it out. In regard to the first heading, he maintained that the present condition of things necessitated some speedy agreement between the Powers, and though the difficulties of adjustment appeared to be great, yet earnest co-operation should overcome them. Mr. Goschen had already expressed the willingness of the British Government to meet on equal terms any reduction of the naval forces of other countries. A great deal of good work was to be expected of the Conference in the matters under the second heading. The Red Cross Society was the outcome of the Geneva Conference, the stipulations of which referred chiefly to land warfare, but it was proposed to extend them to naval warfare as well. Any amelioration of the condition of those engaged in defending their country, which might result from the Conference, would alone justify its existence. Arbitration had been for some time regarded as a possible substitute for brute force. There would no doubt often be difficulties in finding an impartial tribunal among nations, but if some definite principles could be established on the lines of which an endeavour at mediation would always precede a declaration of war, the possibility of successful arbitration would be vastly improved, if not absolutely secured. The people were as much responsible for war as the rulers. They were naturally aggressive, and not the least of the benefits of this peace movement was the powerful moral influence it would exert, which would tend to the gradual development of the idea of the value of peace and of the abhorrence of the evils of war. Success of the conference inevitably depended upon the support and co-operation of the Powers, and an endeavour should be made to make it a land-mark in the moral progress of mankind and a memorial of a better understanding between the nations for the future. Great Britain, as a peace-loving country with vast commercial interests, had everything to gain by supporting measures which tended to the better security of peace, and it was most satisfactory that she had taken the lead in the Tsar's noble efforts.

Mr. A. J. Cleveland, in opposing the motion said, that one thing which was in Mr. Stamm s favour, besides his own eloquence, was that the scheme appealed strongly to the sentimental side of our nature, and was so strongly in accordance with those religious maxims, which so many preached and so few practised. And, again, if they would pardon the paradox, he might say that its main strength lay in the multitude of its weaknesses. With regard to the expediency of the proposals, he could only say that it would be folly for us to reduce our armaments unless the other powers did the same, and since the Tsar had published his manifesto, Russia had voted nine millions of pounds as an extra subsidy for the increase of her navy. Germany wants to increase her huge army, and France openly avows her determination to maintain an army equal to that of Germany, and a navy that can equal, if not beat, our own. America is constructing a fleet as rapidly as she can, which will give her a voice in the world s politics. Japan is re-organising her army and perfecting an already powerful navy. Mr. Cleveland then pointed out that it was expedient for England to maintain her position as the premier naval power, and that it was impossible for us to decrease our annual estimates for warfare as long as our neighbours continued to act as they were acting. There was no reason why England should act as the world's philanthropist, to her own detriment. Nations, nowadays, were just as individuals. A man, to get on in the world, must be equipped with several accomplishments. So with countries, and he (the speaker) rejoiced that England was well equipped for the wide world struggle for existence. "We have the ships, we've got the men, and we've got the money too," represented the true position of affairs in this country, and it would be inexpedient for us to cripple our power because our neighbours are impoverished. Mr. Cleveland said that he could not look upon the question with the eye of a political economist, as political economy was a subject of which he was totally ignorant, but still, he was sure, from an economic point of view the Tsar's peace proposals would not hold water. Then, as to the phrase "The general well being of mankind," he said it was one which would appeal to the Exeter Hall section of the British public, that section which made us so ridiculous over the Armenian atrocities, and which has gained for us a reputation for cant all over the world. Mr. Stamm had talked about arbitration, but what had been the experience of arbitration? It had been a failure from beginning to end. The Delagoa Bay question had been arbitrated

upon for nine years. Did they suppose that England would have waited nine years for Major Marchand to clear out of Fashoda? Nations again, like individuals, had tempers, and when they were aroused would prefer to appeal to guns rather than the legal quibbles of international jurists.

Rev. L. B. Sladen rose to speak for the first time, and was accorded a hearty welcome. He said that it was ridiculous to say that England was such a wealthy country when there were thousands living round Guy's Hospital, and hundreds of thousands in London, who were leading a hand-to-mouth existence. How many thousands near them were paying eight shillings a week for the rent of two rooms, when their weekly earnings only amounted to £1 5s! These people did not pay very much in direct taxation, but indirectly through this exorbitant rent they paid more to the national exchequer in proportion to their means than the wealthier classes. If as a result of the Peace Conference some of the forty millions, which had been voted this year for our war estimates, could be used for the alleviation of the abject poverty of London, a great work would be done. Mr. Sladen went on to say that all great reforms had a beginning, and that the primary movers at first were regarded before their time. This question was not one of sentiment, as Mr. Cleveland had endeavoured to make out, and he would remind them that the abolition of slavery in the first place had been regarded as altogether idealistic and impracticable, but by perseverance it was brought into actual reality. He hoped the Tsar's peace proposals would meet with every support from the nations of Europe, and that arbitration would be given a fair trial, for this could bring about what was most important at any time when the feelings between nations were strained, and that was delay.

Mr. W. C. C. Pakes regarded the Tsar's proposals as a bogus affair. He thoroughly agreed with Mr. Cleveland on the question, and said that Russia at the present was doing everything in her power to fortify her position in China and on our Indian frontier, in spite of her assured sincerity in the proclamation of the Tsar. He said that the final struggle would be between the Briton and the Tartar, and that we must view with distrust any proposal such as the one under consideration, and coming from such a quarter. As long as the world was divided into different nations, so long would there be patriotism, which Mr. Pakes said was one of the greatest virtues, but if they did as the movers of the motion wished them to do, patriotism would be no more.

Miss Moore said that the Tsar had the interest of Russia at heart, and that it was for the betterment of his country that he had invited the great Powers of Europe to consider if something could not be done for the disbanding of many thousands of armed men.

Miss Kidd opposed the motion in a vigorous speech. She dealt with it from the point of view of political economy, and quoted Tennyson, Kipling, Browning and other authors in support of her arguments.

Mr. Shufflebotham said that the Jingo spirit which had been infused into the discussion by Mr. Cleveland and Mr. Pakes was the result of reading the *Daily Mail*, and he asked those gentlemen to cultivate a less sensational style of literature. He said that many Englishmen were sceptical with regard to good intentions coming from the Tsar of Russia. There had been more than a generation of suspicion and distrust, and the old question had been raised, "Can any good come out of Nazareth?" He assured the House, however, that there was not the slightest foundation for this feeling, and asked what could have been the Tsar's object had he not been sincere? He believed that it was in the spirit of true kingship that he had advanced these proposals, and for the moral and material benefit of the millions over whom he had been called to rule. His action had created an opportunity which in all probability could not have been made by one less powerful, and the greatest of all the interests of mankind—the interest of peace—might get such consideration as otherwise would have been impossible. If these proposals received a fair hearing, he had a hope that the sentiment of peace might be universally cultivated. Mr. Shufflebotham went on to say that it would certainly make war expenditure more tolerable if we could ensure that justice was always triumphant. But was this so? No, it was not justice, but the strongest and best-equipped battalions, be their cause right or wrong, that invariably won the day. By supporting the motion the House would not bind itself to any ignominious policy, to one of "Peace at any price." It would simply mean that the proposals would be judged according to their merits. The question under discussion was no party question, no sentimental question, but one essentially of common sense. In conclusion, he said that it was a reflection upon the vaunted civilisation of this century that brute force should prevail against reason and justice.

Mr. Fortescue-Brickdale said that he and the four ladies which he had brought with him would vote against the motion, because they were of a peaceful turn of mind, and they believed that the peace proposals would undoubtedly lead to war.

Mr. A. R. Thompson said that history had repeated itself. The present Tsar's grandfather went in for peace proposals when Russia was in a state of bankruptcy, and the present Tsar was doing the same thing. This was the only course open to him. Mr. Thompson thought that the maintenance of order depended upon physical violence both as regards nations and individuals, but the main reason why he would vote against the motion was because the peace proposals might be the means of letting loose millions of men whom everyone knew to be the scum of Europe.

Mr. T. G. Stamm spoke for the motion, and the vote was taken. For the motion, 33; against, 80; majority against the motion, 47. About twenty members did not vote.

Mr. W. C. C. Pakes proposed a vote of thanks to the President, and the House then adjourned.

Passim.

Our readers will already have gathered from the public Press particulars of the origin and constitution of the League of Mercy. An organization so designed as to reach the whole population of the Home Counties should be of immense service to the Prince of Wales's Hospital Fund for London, of which Fund the League is an auxiliary. Mr. Cosmo Bonsor, as one of the hundred Presidents of the League, is throwing himself into the work with all his accustomed unselfish energy. We wish the League well.

The honorary degree of LL.D. has been conferred upon Dr. Goodhart by the University of Aberdeen, and the news will be greeted with great satisfaction by all Guy's men. Both the University and Dr. Goodhart are to be congratulated, the former for the wisdom of their choice, the latter for the well-deserved honour.

For the last fortnight all has been toil and turmoil in the surgical wards, owing to the general transference of surgical patients to their new wards. The female wards were re-arranged the week before Easter, and the male wards this week; this done, peace once more reigns, and the various exiled surgeons and sisters are commencing to settle down to their new quarters and collect their thoughts.

Dorcas has now been re-opened as a surgical ward and is a great success. If all the surgical wards are to be renovated on the same scale the surgical buildings will be much improved, and will be brought up to date as far as such an old building permits. The walls will not support a heavy tiled or mosaic floor, so a very close-fitting hardwood floor has been laid down, all the ceiling corners have been rounded off, and shelves as far as possible done away with. But the triumph of the whole scheme is the invention of the featherweight beds, and Dr. Perry is to be congratulated upon the idea. These new beds are made upon the premises, out of thin iron tubing, and the whole bed is exceedingly light, and can be moved and lifted with great ease, at the same time being quite rigid. For convenience in giving anæsthetics, the top of the bed takes off bodily instead of letting down.

With the re-opening of Dorcas, Queen Victoria is now used for gynæcological and obstetric beds only, Dr. Galabin having fourteen beds, and Dr. Horrocks ten. The ward for labour cases is also ready for use, and at the present time is only waiting to be re-filled.

The old wooden staircase from the Colonnade up to Samaritan has now been pulled down to make way for the lift shaft, and with the staircase we lose one of the oldest bits of the hospital. This especial staircase is represented in the engraving published by the Gazette last Christmas, and is there styled the "Grand Staircase." Ideas have altered since 1721, for of late years it was considered the height of inconvenience, both from its steepness and small width. Historically it is a great loss, but one cannot have both modern convenience and old associations in the same building.

By order of the Staff and School Committee, from April 3rd all prescriptions will now be dispensed in accordance with the British Pharmacopœia, 1898, and the Guy's Hospital Pharmacopœia, 1899. A number of advance copies of the Guy's Hospital Pharmacopœia have been obtained for the use of men at the Hospital, and can be obtained at the Medical School Office, while the remainder of the edition will be on sale at Grattan's in the course of a few days. Meanwhile we are requested to state that prices quoted for the Pharmacopœia in last Gazette are "nett."

Colonel Ford, Her Majesty's Chief Inspector of Explosives, has sent a circular to all the medical Press, requesting them to make public the dangers attending the use of Erythrol Tetranitrate, a drug which has been much used of late in the treatment of angina pectoris. He says that in 1897 a chemist lost his life by mixing some with lactose in a mortar, and last year a serious accident occurred through some of the drug being accidentally thrown into the fire. As its explosive power is greater than that of either gun-cotton or dynamite, it should certainly be handled with great care.

The Annual Ladies' Night of the Debating Society was held on March 25th, and was an unqualified success. The peace crusaders had a poor time of it, and undoubtedly the better speeches were made by the opposition. Mr. Shufflebotham came in for a deal of heckling by Messrs. Cleveland and Pakes, and these little passages gave the necessary life to the otherwise strictly decorous proceedings. Two ladies

spoke, and their speeches were distinctly good, being far above the average, the usual feminine vice of at once straying from the point being happily absent. Finally, the Debating Society is to be congratulated on a most successful year, the debates having been better attended and more lively than those of the past few seasons.

We notice in "Nursing News" that the Dispensary Examination was held on Monday, March 27th. There were fifty-three candidates, all of whom passed. How heartbreaking to personal ambition to be included in such a list! We begin to think that the Spartan Mr. Collier, is becoming susceptible to the blandishments of the fairer sex, and does not like to hurt their feelings. As his best friend we would warn him against such weakness.

We notice in the columns of the *Stethoscope*, the Bristol Students' Journal, a somewhat erroneous statement. After very nicely lamenting the decease of the *Guyoscope* they announce that the staff of this same organ are about to start an inter-hospital magazine called the *Medico*, and that contributions will be paid for—a hitherto unheard of practice in the Medical Press. We think the *Stethoscope* is misinformed. There is a projected inter-hospital magazine called the *Medico*, which is billed to make its appearance this month, but it will not be run by the *Guyoscope* Staff. The editor is unconnected with any hospital, and the *Medico* hopes to be attractive to the men of all hospitals by reason of having contributions from them all equally as far as possible.

By the kindness of the Editor of the late *Guyoscope* we are enabled to publish in this number of the Gazette two drawings by Mr. Gerald Sichel, now Surgeon in the Navy. From his position in the service his opinion upon the subject of the drawings is invaluable. We are also requested to announce that many of the originals of caricatures in the *Guyoscope* are still on sale and can be obtained from Mr. Pamment in the Medical School Office.

Concerning the D.P.H. We would strongly advise all men who are intending to go in for this diploma to commence the course directly they are qualified, and before going out into general practice. The examinations have been getting progressively harder for the last five years, and it is now impossible to attempt to do the D.P.H. with a few weeks' reading after a year or two in practice. Also it will be in the future practically compulsory for any man wishing to become a Medical Officer of Health to have the Diploma.

Everybody will be glad to hear that R. C. Mullins, who is ill at Brecon, is getting better, and in a fair way to convalescence. He originally got a poisoned finger at the Hospital, and went away before he noticed it. He got extensive cellulitis of the arm and septicæmic symptoms, and at various times upwards of a dozen incisions were made into the arms. Happily now he seems on the mend.

A Dance will be given by the United Hospitals Rifle Association, at Addison Hall, Kensington, on Friday, May 26th, 1899. Tickets, price 5s., can be obtained from H. E. Weeks, 19, Sinclair Gardens, W., and St. Thomas's Hospital, or H. Stanley-Turner, Guy's Hospital.

Nursing News.

On March 24th, Probationer Martyn was appointed Head Nurse in the Isolation Ward, Nurse McKinley having completed her three years' training.

On Monday, March 27th, Dorcas ward was re-opened, and the general move of the Women's Surgical Wards commenced, nine new Probationers entering to facilitate the work. Miss Godby (Sister Charity), moved into Dorcas; Miss Fox (Sister Martha), into Charity; Miss Davidson (Sister Lydia) into Martha; and Miss Crawley (Sister Eva, Medical Night Sister), took up her duties as Sister of Lydia Ward, in each case the Head Nurses and Probationers moved with the Sisters.

On April 1st, the Maternity ward, Victoria, was ready for occupation, and Nurses Tippetts (from Stephen) and O'Neill (from Lazarus) took up their duties as Pupil Midwives.

Probationer Roffey has succeeded Nurse Tippetts as Head Nurse in Stephen, and Probationer Lane, Nurse O'Neill in Lazarus.

Probationers Andrews and Daniell have been appointed Head Nurses in Lydia ward.

The Dispensary Examination was held on Monday, March 27th. There were fifty-three candidates, everyone of whom passed. Equal First—Nurse Bowen, Nurse Knox. Second — Probationer Cooper (Lady Pupil). Third—Probationer Potter.

(THE IDEAL.)

(THE REAL.)

"THE LASS THAT LOVES A SAILOR."

Guy's Hospital Dental Society.

There was a meeting of the above Society held on February 21st, at 5 p.m., the President, Mr. Hopson, in the chair. The minutes of the previous meeting were read and confirmed, after which the following casual communications were brought forward.

Mr. Plumley showed (*a*) a good specimen of epulis removed from superior maxilla; (*b*) an upper model showing transposition of canine with lateral; (*c*) an upper model having three premolars on the right side and a molariform supernumerary between the two centrals.

Mr. Dowsett showed upper and lower models of well-marked syphilitic teeth.

Mr. H. W. Morris showed an upper model with a supernumerary *in situ* which had been displaced by eruption of molar three.

Mr. Wartski showed a lower model in which there was a very large space between the first and second premolars.

A good discussion on the casual communications then followed.

The President then called on Mr. C. S. Morris for his paper on

A FEW CONSIDERATIONS ON CROWNING.

Mr. President and Gentlemen,—The subject that I wish to bring before you this evening is a very vast and complicated one, and one that I cannot hope more than to skim the surface of. I shall, therefore, confine myself to one form of crowns, namely, banded—as that is the system that I am most competent to speak on. After a few general remarks, I shall endeavour to trace before you an ordinary crowning operation from its commencement to its close, touching more particularly on those points that are usually regarded as most difficult. I shall here and there perhaps have to take for granted that my hearers know such details as fitting and soldering a tooth, etc., in the laboratory; to go into these minutely would make the paper unduly lengthly, when the time is already too short to deal adequately with my subject.

I shall endeavour to make my remarks as original as possible—that is, as original as they can be from one who has gone into an entirely new field,—because I feel I could not speak with certainty about that which I have not had the opportunity of putting into practice.

The first point then is—When has a tooth reached the stage for crowning? I think no tooth ought to be crowned when it can possibly be satisfactorily filled. By satisfactorily filled, I mean filled in such a way that there is a good chance of the filling preserving the tooth four or five years. I think we are apt, when we see a tooth very badly decayed, to decide too hurriedly that it should be crowned, when in reality the life of the organ could obviously be prolonged several years by filling it first and crowning it ultimately. We often see very large cavities in teeth which upon examination do not extend any distance below the gum margin, or if at all, very slightly. These are in a condition to be filled. We all agree that where a filling fails most commonly is along the cervical margin, and if that fails in these cases they are still capable of being crowned; because there remains tooth substance enough generally to fit a band over at that point. The cases that should not be filled are those in which the decay has proceeded some distance below the gum; because, if they fail, there is then no likelihood of getting a band down, and the next operation is usually extraction. I have seen several teeth that have now been filled three or more years, which at the time appeared to have reached the crowning stage, but are still existing as useful organs with crowning yet to come. As a general rule, however, we are driven to crown the anterior eight much before the posterior, because of the disfigurement of large fillings.

Now, having decided to crown the tooth, the next thing to be considered is, if the pulp is alive, whether to save it or to destroy it. It might be argued that a live tooth is always better than a dead one. It is not always so. To trim up a live tooth, from say $\frac{1}{16}$th of an inch below the gum, is an exceedingly painful operation, and if there is anyone here that has had one done, they will be able to appreciate this point. It nearly always means this, that the tooth is coned up as much as the patient allows, and not as much as the operator desires. The result of this is, that we pain and tire our patient, and tire ourselves, and get an ill-fitting band, with a chance that after all our efforts, the pulp will ultimately die from thermal changes. Therefore, in all cases of crowning, the best treatment is to devitalize the pulp. This is especially the case in bridging, where it is often necessary to cut a considerable amount off one side or other of a tooth, in order to make the abutments exactly parallel from the gum line upwards. It is, of course, obvious that a pulp must be killed for any crown with a post.

We can now discuss trimming or coning up the root. A root should be trimmed up so that the sides are just off the parallel, that is, so that they form a cone, which is only the slightest degree smaller at the crown than at the neck. I see no use for making the root a decided cone. The strongest crown must be that which contains the least amount of cement between it and the root.

As a general rule the band should not fit up under the gum more than about $\frac{1}{16}$th of an inch.

There are exceptions to this in those cases where the root is much broken down at some point or other, and there, in order to get a hold on the root, the band must go down considerably further. Care must be taken, however, that the band does not in any way impinge upon the periosteum, or else chronic periostitis will be set up, and the tooth will gradually loosen and be ultimately lost.

To trim up the root from $\frac{1}{16}$th of an inch beneath the gum, without any previous preparation, is a very tedious and painful operation, causing much laceration and bleeding, ending in the operator not being able to see what is the shape of the root.

There are many methods for forcing the gum back from the neck of the tooth, but the best that I know of is a transverse section about $\frac{1}{8}$th of an inch long cut from a piece of French tubing slipped over the tooth, and left for about thirty-six hours before the operation. In order to effect this neatly, proceed in the following way. Make a short appointment with the patient thirty-six hours before, and, if it be necessary, cut down the mesial and distal walls of the tooth sufficiently to allow the rubber ring to slide up over the root. For this I strongly advise Garnet paper discs, stiffened with a steel disc. They cut better than any kind of stone. If the tooth is broken down to such an extent that the rubber will not stay on, build it up with cement. It will sometimes be found that the ring, if pushed up will grip rather too hard against the neighbours, even after the walls have been cut down; if so, double the ring up between the thumb and fore-finger, and, with a small pair of scissors, cut two or more pieces off the surface, parallel with one another, and longitudinally with the tubing, on the mesial and distal sides where it touches. When the rubber band slides up without squeezing against the approximal teeth, take a small pair of scissors, and contour the cervical margin of the band to exactly fit the gum. And then bevel the cervical margin of the band at the expense of the external surface to the extent of 45°, so that, when slipped on, it forms a kind of circular chisel with the cutting edge against the neck of the tooth and towards the gum. This latter cutting is to ensure the gum being forced away from, as well as down the neck of the tooth. Slip the tube over the root, and press it up till it whitens faintly, and send your patient away. The food during mastication will keep the tube sliding up the root meanwhile, and when the patient returns the gum will be found to be not only forced up, but away from the root, admiting of easy access with instruments and wheels, to the required distance down, without laceration. It may be said that this is a great deal of trouble for so small a thing. It is not really so. In the first place, the mesial and distal walls have to be cut down some time; and in the second place, the time saved by being able to see what one is doing, and the pain saved to the patient, is well worth the few minutes spent in the first operation.

The root having been prepared for trimming, we may now consider how to proceed. If the tooth is to have an all-metal crown fixed on, first cut down any cusps standing, sufficiently to allow for the thickness of the cusps of the crown, leaving the root as high as possible to give the greatest strength. But if the root has to have any modification of a Richmond or a crown requiring a band and cap, leave the root half as high again as will be required for the band. The reason for this is, that if the root is ground down in the first place as far as is needed, the instruments, whether Stone's or Cleaver's, always round the top of the root, so that the root is parallel for a short distance below the gum, and then terminates in a rounded top, which makes it very difficult to fit to it a parallel sided band with any grip. Whereas, if the root is left higher than is necessary, and then after the band is fitted, the rounded top is ground down, a flat top to the root and sharp angles are obtained, admitting of the band gripping the whole of its depth.

I shall now have to deviate for a few minutes to discuss the few instruments that I find most effective for removing enamel and general shaping. They are, Howe's scaler and Case's enamel cleavers, three or four stones, two modified cup shaped stones, and two modified wheels and an ordinary wheel; for the rest, dry Garnet discs.

Howe's scaler is an instrument that requires to be held in a certain way to be really effective. Suppose, for instance, that we are trimming a left upper canine, and want to remove the enamel from the mesial surface; the fore-finger of the left hand should be placed on the gum between the roots of the lateral and the canine on the anterior alveolar plate. The scaler should be held like a pen in the right hand with the point directed forward. Then place that part of the instrument, opposite the ball of the second finger of the right hand, against the inner side of the left thumb, using the thumb as a kind of moveable fulcrum, to push the instrument forward, and the right hand to lever. By this means both hands support one another, there being comparatively no chance of slipping and an almost rigid stroke can be obtained. By modifying the position of the left fore-finger, the cleaver can be used to remove enamel from any point of the root.

We will imagine that we are trimming up any of the eight anterior teeth. Having cut the root down, take a Garnet paper disc, backed with a thin steeled disc, and cut down first the mesial and distal surfaces as much as is needed to obtain more room for our stones to get round the angles. Then use the cup-shaped stone with the hollow surface against the tooth, to reduce all the labial wall, the hollow allowing the operator to work somewhat between the teeth. It will be found that some angle will be left at the junction of the distal and mesial surfaces with the labial. Then, with the outside of the stone, reduce the palatal wall. The palatal angles cannot be so well rounded, because the position being inside, the mouth does not admit of the necessary room. The root at this stage, presents two nearly flat sides—mesial and distal—two labial angles and two palatal angles; the palatal angles being less reduced than the labial. To round and reduce these angles use dry Garnet's discs, without any backing. Supposing the labio-distal angle of a first upper left bicuspid is to be reduced, the disc should be soaped or vaselined on the back, and run up between the root and the approximal tooth, and then with a plastic spatula in the left hand bent round the root and slid up beneath the gum, while the engine is in motion, the spatula holding it against the root labially, the approximal tooth keeping it somewhat in position behind. It will be found that, in this way, the angles can be reduced pretty quickly, the thinness of the disc admitting of it being pushed up beneath the surface of the gum with little laceration. With a little manipulation all the angles can be reduced in a similar fashion.

The thing to guard against, is the use of large and thick discs, both being hard to control.

If the angles are not sufficiently reduced and no more can be done with discs, use Howe's scaler. The enamel on these parts is now so thin, that, with a small sharp-pointed scaler or Case's cleaver, the enamel can be cracked and then with a larger cleaver, pretty readily removed by using the instrument in the way that I have described above. The disc may be required again just to smooth off any roughness finally.

This method can be employed generally to trim up all roots that are to be fitted with a cap. But for roots that are to have an all-metal crown put on, it will be found that the cleaver's are not of much value, because the amount of tooth substance to be removed is much greater, the root being left considerably higher, except at those places where the root is very broken down. The general rule in these roots is to use big stones to reduce the bulk of the enamel, and then use the finer stones to get the final shape. The small stones will soon wear out if used to trim an entire root. The same order, however, for reducing all roots should be observed.

The root having been trimmed up satisfactorily, the band can be now fitted. First with a pair of dividers measure the depth of band required, and then, with a dentimetre, measure the root with thin wire—not too thin—just at the level of the gum, or if the gum has been forced back to where the gum would reach. Remove the wire ring, tap it into a flat slab of lead with a hammer. Draw the wire from the lead and cut the ring in two, and spread it out straight. Place it on the metal from which the band is to be made, which should be 28 or 29 American gauge, and cut it about $\frac{1}{32}$ inch. shorter than the wire, having marked the required depth, first, with the dividers. Cutting the band shorter than the wire is to allow for stretching, etc., during manipulation. If the root has a shape much removed from a round or oval, it pays when bending the band to fit it roughly into the impression in the lead, before soldering. By doing this the band will slip on the root up to the gum line easily, and in roots very broken down it saves much trouble.

Before uniting the band care should be taken to see that the edges are fitting against one another accurately, leaving only a fine joint to be united. This should be moistened from the inside with a borax solution on a small hairbrush, and a very small narrow piece of solder laid in the joint on the inside. When soldering, heat it slowly at first, else the water evaporating from the solution will jerk the solder out of place. When soldered the line of solder showing on the outside should not be thicker than a hair.

The band should then be contoured on the cervical end where it is seen to need it, to fit the gum, and pushed gently on to the root. It will be found, that, if the band has not been fitted into the impression in the lead, it will not go up to the gum line without some forcing. When it is pushed up as far as is possible with the fingers, without undue pressure, take a small rivetting mallet, and with a wooden punch tap it gently. This does it with less inconvenience to the patient and effects it more rapidly. When it touches the gum, if necessary, mark with a sharp pointed instrument where more metal must be sculptured out in order to fit the gum, draw it off, file out the amount and level the edge. I must here deviate for a few minutes in order to consider the differences between making an all-metal shell crown and a cap crown.

In making a cap crown, when the cervical end of the band fits the contour of the gum, the root, which has previously been left higher than is required, should be ground down till it is projecting from the gum a little over a $\frac{1}{16}$ of an inch. In bicuspids it can be left a little higher with advantage. The labial or buccal edge should then be ground down so that it lies a little below the gum line, the top of the root presenting to planes. This being done, take the band and push it up to the gum, and then tap it up as before till it is covered by about $\frac{1}{16}$ of an inch of gum. If the root has been trimmed properly, this will cause the patient no inconvenience. With a sharp-pointed instrument scratch the inside of the band all round on a level with the top of the root; remove the band, and cut and file it down to this line very carefully, in order not to bend it. Place the band on the root again, and then with a stone grind it down accurately on a level with the root, revolving the stone as much as possible from the gum to the centre, then remove the band. The metal to form the cap can be considerably thinner than the band, 32 American gauge being plenty thick enough. I see no use for having a thick cap when it is to be covered with solder, and it is certainly much easier to solder on a thin cap, and it is also much easier to fit it out of sight at the labial margin. As little solder as possible should be used to unite it—in fact, this applies to every part of crown work.

The post should then be fitted to the canal. It should fit the canal exactly, and be of a good stout size, with its greatest diameter in the direction of the greatest strain. The cap should now be pushed on the root, and a hole drilled through over the canal, and the post pushed into position. Some hard wax melted over the pin and cap, preferably Parr's flux wax, to hold them together, and both removed and soldered. The quickest way to do this is to push the pin into a ball of Mellote's mouldine until the cervical rim of the band is covered; the investment can be then heated, and the wax burnt off and soldered with little waste of time.

The cap should then be cleaned and placed in position the post being left sticking above the cap about $\frac{1}{8}$th of an inch, and a tooth chosen. This is best done at this stage because the size and length can be better judged with the cap in position. An impression in plaster, or Teag's compound, should now be taken, bringing the cap away in the plaster. A slight impression of the opposing teeth should be taken in Stent's, the closure noted, and the models taken to the laboratory and cast, first veneering the inside of the band and post with wax. The rest of the operation can now be completed without the

patient. For making a crown for any of the anterior six teeth, no more is needed than this, but for bicuspids a bigger impression of the occluding teeth must be taken, and the models set up in a crown articulator. There is just one remark I should like to make about polishing, and that is, that all crowns fitted with a porcelain tooth to a cap. are better polished with discs, so that the joint does not become dirty, as it would with pumice.

In making an all-metal shell crown, after the cervical end has been contoured to the gum, it should be adjusted, and with a sharp pointed instrument a line drawn on a level with the base of the cusps of the approximal teeth, and removed; with a pair of shears cut down to this line, and the whole end filed perfectly flat with a broad and fine jeweller's file.

We may now consider the contouring. For this I much prefer a small oval ended instrument or anvil held in a vice, and the band expanded by hammering it with a small rivetting hammer over those places where contour is needed. It will be found that a contour can be effected in this way very evenly and very rapidly. Much also can be done by heating the band and dropping it into Stent's, and then bending the outstanding edge with ordinary contour pliers.

The right amount of contour having been produced—which requires two or three trials sometimes in the mouth—the band should be placed in position and filled with Stent, sufficient to cover the two approximal teeth, and the patient asked to close on it till set. It should then be removed carefully, care being taken not to break the Stent, and then the band and Stent set up in a crown articulator. When set the Stent can be warmed and removed, when an exact position of the teeth and their relation in occlusion will be obtained, with the band in position.

There are many ways of striking up the caps, and soldering, &c., many of which I have tried, and none of which I altogether like. I, therefore, adopted a system which has suggested itself to me while trying other methods. By this I have been able to do the best and most artistic work, so for that reason it is laid before this society.

When the Stent has been warmed and removed as described above, take a pair of dividers and mark the distance from about quarter of an inch above the occluding surface of the plaster teeth on each jaw, making little holes where the fine points of the dividers come. Then, with a knife cut away sufficient of the masticating surfaces of the teeth on each side of the band, leaving the buccal cusps standing to allow the bite to close about twice the thickness of the gold for the cap. Twice the thickness of the gold is needed, because the die is always condensed somewhat and shortened, especially on the cusps, by swaging, with the result that when it is placed on the plaster it never quite fits down into the sulcus.

When this has been done, oil the occluding teeth and fill the band up with plaster mixed with hot water and salt, and the articulator closed. In three minutes the plaster will be perfectly hard, and is ready to be carved up into cusps, etc. Plaster is much preferable to Stent or wax for this, as it cuts much cleaner and easier, and, if mixed in this way, is not appreciably slower. Next carve up the plaster, when the articulator has been opened, to the required cusps and fissures, cutting the fissures deeper and sharper than is wanted on the crown. When this is done and the articulation seen to be correct, and the cusps a corresponding length to the approximal teeth, remove the band from the plaster model, and with a sharp knife cut the plaster of the carved up plaster cap, back from the top of the band, about half the thickness of the gold; the reason for this will be seen presently. French chalk the plaster cap, and fill a Mellote's tray full of mouldine, and place the rubber ring on, then take a ball of the mouldine and press it on to the plaster cap with the finger and press the whole thing into the tray of mouldine and remove the band and plaster. In this way a very sharp impression can be taken. Next cast with fusible alloy, getting it just more than melted before pouring. If it is poured too thick the metal does not run into the fissures, and if too hot it burns the mouldine, and a frosted rough spiny surface is obtained. When the die is cool, strike three counter dies in a lead slab; the first slight, the second deeper, and the third the full depth of the cusps or more. Take a square piece of metal, more than big enough for the crown, and then, on any part of the lead slab, give it one or two slight taps. This will knock it into position sufficiently to allow it to be placed in the first counterdie without sliding when struck. Strike it up now, well into the three counterdies in succession, annealing between each. Heat the cap and drop it into dilute sulphuric acid, when it will be instantly cleaned, and a definite line where the top of the band comes will be easily seen.

With a light pair of shears cut round on this line, and then file it down perfectly flat on a broad finishing file. It may be found that the cap is slightly bent out of shape with the cutting, if so give it a tap into the first counterdie. The cap should now fit the plaster crown perfectly, but it will be noticed that it appears a little too big just at the joint, that is, that the cap sticks out beyond the top of the band at that part. Take a knife and cut the plaster back from the top of the band more than the full thickness of the gold, place the cap on and hold it in position by pushing it against the peg at the bench, and burnish the outstanding ledge in. By doing this, the edges of the cap and band can be made to meet accurately edge to edge.

If the plaster had been cut back the full thickness of the gold at the top of the band in the first instance, the result would have been that the gold would have been driven into the niche, and when filed up would leave a depression running round the crown just above the joint, however carefully it was done.

Next fill the cusps almost flush with high grade solder, this should not require much if the crown has been carefully made, and the band left as high as possible,

Push out the plaster from the band, and heat both cap and band red, and drop them in sulphuric acid dilute as before; wash and dry them. Then with a ball of wool dipped in a solution of borax, smear the top of the band and the inside of the cap; wire the cap on to the band and place three or four narrow pieces of solder in the joint, dry over a Bunsen, and then solder. The solder will be found to flow like a flash all round. There only remains now the polishing, which is very simple. It will be found much easier, however, to polish all metal crowns, if, after the soldering, a deal stick about six inches long is fitted roughly into the crown and all the subsequent polishing done with the crown fixed on to the end. By this means we have a handle, so to speak, to hold it by.

It is often found that a root is so broken down all round that there is not sufficient of it standing above the gum line to support a crown without a post of some kind. And, in closing, I should like to say a few words about this.

As it is unquestionably the soundest practice to have the post soldered to the crown, instead of cemented in the root, and the crown adjusted separately—except perhaps in the case of upper molars, where there are three divergent canals—this is a very trustworthy method. The band having been contoured and ready to take the impression of the occluding teeth as has been described before, fit a stout pin into the canal and leave it sticking up above the top of the band about $\frac{1}{8}$th of an inch or more if required. Draw it out and flatten that part of it sticking above the band and split it down with strong shears, and bend one to the distal and the other to the mesial surface at right angles, and adjust it into the canal. Then push Stent into the band and round the pin, and take the bite as before, pouring a stream of cold water over the Stent before removing to make it properly hard. Set it up in a crown articulator and remove the Stent and fit the split ends of the pins just inside and below the top of the band, and unite them to the band while on the model with a small piece of solder. Proceed then as in an ordinary crown. When the last stage is reached—that of soldering the cap—the solder in the cap will be found to almost touch the cross pins of the post; place a fair sized piece of solder on this point as well as in the cap joint and solder all together. In this way a perfectly rigid and accurately fitting post can be obtained without much trouble.

For fixing crowns, oxyphosphate is the most universal material, and it is a very easy material to work except in those cases where a post is used, and to this reference will be made more particularly after a word about mixing. The acid and the powder should be mixed together in their right proportions at the outset, and not added little by little, else one part of the powder will be incorporated with more acid than the other. They should, when first mixed, form a thin cream, and then be rubbed well up together till the mixture forms a perfectly smooth but thickish cream, when it should be smeared into the crown and the crown inserted. This is an easy matter in all metal crowns, but where there is a canal to be filled it will be found that the cement will do almost anything but go up the canal. The way to get over this is to smear the canal, after it has been dried with hot air, with some of the acid on a little wool, then when the cement is mixed, take a very small amount on the end of a fine root canal plugger, and pass it up to the end of the canal without touching the sides if possible, and then smear it against the side of the canal when withdrawing. The wet walls will readily take up the cement from the end of the plugger and distribute it more or less evenly round the canal. Three or four lots of cement will be quite sufficient, if the post fits properly, and it is done quickly and with comparative ease.

When gutta-percha is used—and I think it should be used much more than it is—the crown should be filled with the right amount of the red base plate gutta-percha and heated, and then with an instrument smeared against the inside of the crown. The root should then be dried with hot air, and chloro-percha smeared all round it, and the crown again heated and adjusted quickly. If the heating of the gutta-percha is left till the chloro-percha is put on the root, the chloroform will have evaporated before the gutta-percha can be heated through. The chloro-percha affects the adhesion of the gutta-percha to the root, and makes the superfluous material easy to be removed. This should be done with a fine instrument and immediately, and the chloro-percha wiped off the surrounding gum with a wisp of cotton wool. Gutta-percha is not so easily worked as oxyphosphate, and perhaps is not so rigid, but it is much more durable, and does not irritate the gum.

Another discussion then followed in which the President, Messrs. Goadby, Plumley, Dowsett, Tasker and Wartski joined. A vote of thanks was then given to Mr. C. S. Morris for his excellent paper, thus terminating the meeting.

In Lighter Vein.

The process of ward-moving has been completed without mishap, and for this we cannot be too thankful. In a less well regulated institution very serious trouble might have arisen. Suppose, for instance, the surgeons had not quite grasped the new scheme, what chaos there would have been! Imagine Mr. Howse suddenly discovering that all his patients were wearing aseptic pads; picture Mr. Lucas tearing off "butter muslin" and "green protective"; conceive Mr. Golding-Bird's expression when he found that all his fractures had been wired, or think of Mr. Lane's dismay at finding his beds filled with adenoids. None of these things happened, therefore I say, rejoice.

Victoria ward is now open to the public in its true capacity; it only requires a few patients to make it a complete success. "Empty is the Cradle" might be added as a hymn to the evening prayers.

The state of the ward at the moment of writing recalls Sir Samuel Wilks' story of the patient who said to him "You may talk about the doctors and you may talk about the nusses, but where would Guy's Hospital be without the patients?"

The March Externs deserve the gratitude of all true lovers of art, for they have presented to the Externs' room a pair of rare and almost priceless prints—The two Comrades, "Before the Battle" and "After the Battle." The room now combines beauty with comfort, and the Externs are without a grievance.

This suggests a method of popularising the new ward. Why not purchase portraits of Robert Emmett and hang one over each bed? Then the patients would feel quite "home-like."

In olden days when "bleeding" was popular, the trades of barber and blood-letter were often combined. As far as I know there is no recorded case of a man combining the occupation of barber and obstetrician.

I have been fortunate enough to collect one or two letters which are not without humour. Here is one from a patient to an A. H.-P. She writes—

"Sir my voice is a little better but the pains under my shoulder Plades is all of a burning heath I am suffering all through this week with wind I am boulging it all day long and I have got a dreadful pain in my left side I wish you coudd give me something for the wind with out of changing my medicune the reason I havent come Sir I havent been out of room since last week I thought I get a fresh cold I thought I would explain it you as the same of writing to you your humble servant

"Mrs. McCormack."

The writer of the next is evidently running hard for an F.R.S. Note that he presents his ideas to the world free of charge.

"Sir,

"Sientists and other men have ben trying to discover a substitute for food from time immorial. Seeing some time ago that certian persons had succeeded in liquedizing air, the thought struck me that if this liquid was injected into the blood it would have the same effect as food on the system

"if you think this idea is any good to the profession I shall be glad

"perhaps it will be the cause of saving life when other means fail

"W. E. Somers,
"No. 1 George lane
"Wanstead
"next door to
"George inn.

"Or used as a cure for consumption."

The next was to have been reproduced in the late lamented *Guyoscope*, it is a cutting from the *British Dental Journal* for December last—

To the Editor of British Dental Journal.

"Sir—I am glad to see you take notice of and publish such conduct as in the 'Ibis' advertising case. We need such articles to purge the Registrar. Could you obtain Mr. Goadby's opinions on the pathology of 'green stain' and oblige,

"Yours very truly
"L. Strangeways Hounsell,
"L. D. S. Eng."

So nice for the Registrar!

Mr. Higgins has been taking lessons in the new art of self-defence. At his first meeting with Mr. Barton Wright he attempted to floor him with the usual knock-out blow, but soon found himself presenting an inverted image moving against the shadow. This led him to think that there was more in the method than met the eye.

It appears that there is a good deal to learn in this new art. There are several hundreds of different manœuvres for as many different forms of attack, and the trouble begins, I imagine, when you work off the wrong defence for the particular variety of attack. There is one trick with an overcoat which strikes us as particularly "fresh." All you have to do is to walk in the middle of the road with your arms removed from the sleeves of your overcoat. (The only drawback to this is that it rather spoils the set of the overcoat and necessitates wearing one all the summer). Then you meet your assailant—this is the hardest part of the business, but it can generally be managed by a judicious use of opprobrious epithet. Having met him, all you have to do is to seize your coat by the shoulder and plug it round his head. If you are successful

you can jump on his chest while he is getting himself untangled; if not, he will probably move off with the overcoat down a side street. You lose the overcoat but you win the game. I must try it on a policeman. A.

Chapel News.

The following list of donations towards the £90 required for the central panel of the Reredos in the Chapel will show that the fund is making satisfactory progress. It is hoped that the whole amount will be raised before Whitsuntide. Donations should be sent to the Rev. L. B. Sladen, at the Hospital, as soon as possible:—

	£	s.	d.
Chapel Offertory	6	13	10
Miss F. C. Nott Bower	5	5	0
Miss Esther Young	5	5	0
H. Cosmo O. Bonsor, Esq., M.P.	5	0	0
R. Gordon, Esq.	5	0	0
Dr. E. C. Perry	5	0	0
J. A. Shaw-Stewart, Esq.	5	0	0
Rev. L. B. Sladen	4	4	0
Sir Frederick Wigan, Bart.	3	3	0
Sister Queen	3	0	0
Right Hon. Lord Aldenham	2	2	0
Frank Debenham, Esq.	2	2	0
R. A. Hankey, Esq.	2	2	0
R. M. Harvey, Esq.	2	2	0
Dr. Thos. Stevenson	2	2	0
R. E. Johnston, Esq.	2	0	0
C. H. Wells, Esq.	1	1	0
H. Williams, Esq.	1	1	0
W. A. Brailey, Esq., M.D.	1	0	0
Miss Evelyn L. Harbottle	1	0	0
Miss Lyon	1	0	0
Hostel, per Miss Evans	0	14	3
Nurses, Bright Ward	0	12	0
W. Hamilton Pott, Esq.	0	10	6
K. A. T	0	10	0
Miss Stanyon	0	7	6
E. M. N.	0	5	0
Miss N. Dawson	0	5	0
Miss M. A. Houston, and Friend	0	5	0
Sister Job	0	5	0
Miss Mallandaine	0	5	0
Miss Palmer	0	3	0
Miss McNaughton	0	3	0
Anonymous	0	2	6
Sister Charity	0	2	6
Miss A. M Cross	0	2	6
Miss G. E. Hobbs	0	2	6
Miss E. L. Ramsey	0	2	6
Nurse Pitman	0	2	0
A Mite	0	1	0
Total ...	£70	3	7

University of Cambridge.

EXAMINATIONS FOR MEDICAL AND SURGICAL DEGREES. EASTER TERM, 1899.

Plan of Examination (subject to alteration in details, of which due notice will be given).

THIRD EXAMINATION.

PART I.—Tuesday, April 25th, 9 a.m. to 12 m.—Principles and Practice of Surgery. Wednesday, April 26th, 9 a.m. to 12 m.—Midwifery. Friday, April 28th, 9 a.m.—Oral Examination in Surgery, and Surgical Operations (in the Medical School); 2 p.m.—Oral Examination in Surgery, and Surgical Operations (in the Medical School). Saturday, April 29th, 9 a.m.—Oral Examination in Surgery, and Surgical Operations (in the Medical School); 11 a.m. and 2 p.m.—Clinical Examination, Surgical Anatomy, and Application of Surgical Apparatus (at the Hospital); 10.40 a.m. and 2 p.m.—Oral Examination in Midwifery (in the Medical School). Monday, May 1st, 9 a.m.—Oral Examination in Midwifery (in the Medical School); 11 a.m. and 2 p.m.—Clinical Examination, Surgical Anatomy, and Application of Surgical Apparatus (at the Hospital).

PART II.—Tuesday, April 25th, 2 to 5 p.m.—Principles and Practice of Physic I. (in the Senate House). Wednesday, April 26th, 2 to 5 p.m.—Pathology (in the Senate House). Thursday, April 27th, 9 a.m. to 12 m.—Principles and Practice of Physic II. (in the Senate House); 2 to 4.30 p.m.—Elements of Hygiene and Medical Jurisprudence (in the Senate House). Friday, April 28th, 9 a.m. to 12 m.—Therapeutics (in the Senate House). Tuesday, May 2nd, 10 a.m.—Clinical Examination (at the Hospital); 2.30 p.m.—Microscopical Specimens, and Oral Examination (in the Pathological Laboratory). Wednesday, May 3rd, 10 a.m Clinical Examination (at the Hospital); 2.30 p.m., Prescriptions, and Oral Examination (in the Pathological Laboratory). Thursday, May 4th, 10 a.m.—Clinical Examination (at the Hospital); 2.30 p.m.—Oral Examination (in the Pathological Laboratory).

EXAMINATION FOR DEGREE OF M.C.

Friday, April 28th, 9 a.m. to 12 m.—Pathology, and Principles and Practice of Surgery (in the Senate House); 2 to 4 p.m.—Essay on Surgical Case and Topic relating to Surgery (in the Senate House). Saturday, April 29th, 9 a.m.—Oral Examination and Surgical Operations. Monday, May 1st, 11 a.m.—Surgical Anatomy and Clinical and Oral Examination (at the Hospital).

The names of candidates for the Third Examination for the degrees of M.B. and B.C. and for the Examination for the degree of M.C. must be sent to the Registrary on or before Saturday, April 8th. Candidates who are members of the Senate, and all candidates for the M.C. Examination, may send their names to the Registrary direct. All other names must be sent through the Prælectors of the respective Colleges.

Forms, on which it is requested that the names may be written, have been sent to the Prælectors.

The certificates of candidates, accompanied by their postal addresses, must be sent to the Registrary on or before Wednesday, April 19th.

The fees for each examination must be paid to the Registrary when the certificates are sent in. The fee is £2 2s. for each part of the Third Examination and £3 3s. for the M.C. Examination.

Any candidate whose name and certificates have not been sent in and fee paid at the proper time is liable to pay an additional fee of £1 if he be nevertheless admitted to the examination.

Registry, 23rd March, 1899.

Appointments.

HOUSE APPOINTMENTS.

The following appointments have been made by the House Committee upon the recommendation of the Medical Committee:—

House-Physicians.—Mr. R. T. Fitz-Hugh (Dr. Pye-Smith); Mr. C. Jephcott (Dr. Hale White).

Assistant House-Physicians.—Messrs. K. B. Alexander, E. W. S. Rowland.

House-Surgeons.—Mr. L. H. McGavin (Mr. Howse); G. Chetwode Owsley (Mr. Davies-Colley).

Assistant House-Surgeons.—Messrs. R. H. J. Swan, F. E. Walker (Front Surgery); H. L. Eason (Mr. Jacobson); T. H. W. Landon (Mr. Symonds); A. H. B. Kirkman (Mr. Lane); T. P. Berry (Mr. Dunn).

Obstetric Residents.—Messrs. F. S. Batchelor (6 weeks from April 1st) (Dr. Horrocks); A. J. Cleveland (3 months from April 1st) (Dr. Galabin); P. Turner (4½ months from April 1st) (Dr. Horrocks); H. Leader (6 months from April 1st) (Dr. Galabin); R. Balderston (6 months from May 16th) (Dr. Horrocks).

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants.—Messrs. W. L. Baker, J. T. Dunston, G. N. Meachen, D. J. Munro, F. D. Turner, J. G. Taylor.

Clinical Assistant in the Aural Department.—Mr. C. H. Fagge.

Clinical Assistants in the Medical Wards.—Messrs. J. H. Roberts (Dr. Pye-Smith); H. A. Gaitskell (Dr. Taylor); R. C Mullins (Dr. Hale White); A. Fraser (Dr. Pitt).

Clinical Assistants in the Surgical Wards.—Messrs. H. S. Turner (Mr. Howse); J. B. C. Brockwell (Mr. Davies-Colley); W. H. Brailey (Mr. Golding-Bird).

Clinical Assistants in the Medical Out-Patients.—Messrs. W. B. Hope (Dr. Shaw); E. E. Parrett (Dr. Washbourn); P. C. P. Ingram (Dr. Bryant).

Dressers in the Eye Wards.—Messrs. R. Michell (May 1st) (Mr. Higgens); C. H. Brangwin (May 1st) (Mr. Brailey); J. Matthews, C. T. Hilton (June 16th) (Mr. Higgens); W. K. Wills (June 16th) (Mr. Brailey).

Clerks in the Eye Wards.—Messrs. W. B. Secretan, R. W. B. Hall (1st half); A. Densham, M. J. Rees, H. Bentley (2nd half).

Dressers in the Throat Department.—Messrs. H. C. Sturdy, F. W. Brook, C. T. Hilton, J. Matthews, A. G. Osborn, J. Harris.

Clerks in the Throat Department.—Messrs. H. Braund, G. T. Willan.

Obstetric Dressers.—Messrs. C. B. Sells, A. A. Miller, W. R. Cazenove, C. B. Thomson (April 1st); A. Densham, E. E. Parrett, F. A. Beattie (May 16th).

Surgeons' Dressers.—Messrs. T. T. Kelly, J. E. L. Bates, W. P. Ker, E. Shelton-Jones, J. M. Brydone, J. Alison Glover (Mr. Howse); T. P. Thomas, E. T. Jensen, W. Johnson, E. P. Mitchell, F. A. Segreda, J. L. Whatley (Mr. Davies-Colley); J. Atkins, J. C. J. Da Silva, H. B. Foster, J. S. S. Perkins, F. G. Cross, D. G. Greenfield (Mr. Lucas); G. Lewin, R. D. Attwood, T. R. Beale-Browne, H. McD. Parrott, R. Tilbury, E. J. F. Hardenberg (Mr. Golding-Bird).

Assistant Surgeons' Dressers.—Messrs. A. Moon, P. W. L. Camps, E. F. Reeve, F. D. Welch, J. A. Wood (Mr. Jacobson); W. H. Loosely, L. Pern, H. G. Rashleigh, G. T. Willan, T. B. Fawley (Mr. Symonds); B. Muir, J. A. Butler, P. S. Mandy, R. S. Roper (Mr. Lane); A. C. Ransford, D. Forsyth, A. Pearson, F. G. Gibson, K. W. Goadby (Mr. Dunn).

Medical Ward Clerks.—Messrs. H. Davies-Colley, G. S. Graham-Smith, S. Hodgson, H. K. Lacey, P. T. Manson, D. L. Morgan, F. M. Ommanney, A. C. Osburn, J. F. Robinson, D. W. Smith, F. W. Smith, N. F. Ticehurst, K. V. Trubshaw, F. E. Welchman, M. D. Wood, D. R. T. Griffiths, H. A. Ehrlich, J. A. B. Hammond, S. J. Ormond, C. B. Penny, T. H. F. Roberts, V. M. Wallis, W. O. Roberts, E. C. Bevers, G. Clarke, E. I. Claxton, G. G. Davidson, T. H. B. Dobson, H. S. French, C. R. Howard, R. Thompson, E. F. G. Heap, E. H. Kitchin, F. B. Manser, R. D. Smedley, A. Wylie.

Surgical Ward Clerks.—Messrs. A. Croneen, J. F. Douse, G. T. Collins, G. Evans, C. E. Gaitskell, F. D. S. Jackson, H. C. Keates, D. H. Trail. S. C. H. Bent, W. J. Davies, A. W. Gater, A. C. Nash, W. M. Robson, A. W. Soper.

Assistant Physicians' Clerks.—Messrs. J. E. Collins, R. Jiménez, E. G. Wales, H. Wacher (Dr. Shaw); T. A. Matthews, P. J. Nash, S. S. H. Shannon, J. F. Robinson (Dr. Washbourn); L. Hirsch, R. P. Marshall, F.W. Sime, H. D. Kempthorne (Dr. Bryant).

Clerks in the Skin Department.—Messrs. E. J. Torgue, H. B. Dismorr, A. R. McLachlan.

Post-mortem Clerks.—Messrs. O. Marriott, J. D. Bridger B. W. Moss (April-May); E. A. Miller, A. R. McLachlan, G. M. Brown (May-June); P. C. P. Ingram, T. E. Holmes (June-July).

Obstetric Out-Patients Clerks.—Messrs. H. Braund, C. H. Glenn (1st half); E. G. Andrew, E. W. Goble (2nd half).

Aural Surgeons' Dressers.—Messrs. E. Cohen, F. Shufflebotham, H. S. Turner (May-June).

Dental Surgeon's Dressers.—Messrs. F. W. Brook (April-May); S. A. Ruzzak (May-June); H. M. Hardy (June-July).

Assistant Surgeons' Clerks.—Messrs. F. A. Beattie (Mr. Jacobson); J. S. Cousins (Mr. Dunn).

Clerk in Electrical Department.—Mr. D. L. Morgan (May-June).

DENTAL APPOINTMENTS.

The following appointments have been made by the Treasurer upon the recommendation of the Dental Council:—

Assistant Dental House-Surgeons (April to June).—Messrs. J. Black, H. T. Campkin.

Dressers in the Conservation Room (April to September).—Messrs. R. C. G. May, H. N. Hillier, J. Bennett.

Assistant Demonstrator of Dental Microscopy (May to July).—Mr. R. B. Recordon.

CIVIL.

Burt, W. C., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer to the Tarrington Union, Workhouse.

Mathias, R., M.B. Camb., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer for the Pentyrch Sanitary District by the Cardiff Board of Guardians.

Sport.

Association Football.

GUY'S 2nd v. ST. BART'S. 2nd.

Inter-Hospital Junior Cup.—Final Tie.

This match was played on the ground of St. Thomas's at Chiswick on Thursday 16th. Our team was without Roberts and Lacey, their places being filled by Hilton and Rust. Some delay was caused by the non-appearance of the referee, and eventually the game was started with Mr. Fowler of Bart's. filling the gap. The light was rather bad, and no advantage was to be gained by the toss when Bart's. kicked off.

Bart's. at once took up the attack, and within a few minutes scored through a mistake on the part of our backs. Keeping up the pressure, our opponents kept the defence busy, and put on another goal through Cole hanging on the ball in front of goal. Up to this point Smith was the only man who did himself justice, the other men appearing excited. Guy's forwards now played up hard, Hilton twice breaking away, only to hit the goal-keeper, while Rust shot into his hands. Then Camps scored from a hot attack. Immediately afterwards our goal had a very lucky escape, and Heap saved another shot, but our forwards again taking up the attack forced a corner. This, beautifully placed by Smith, was converted by Rust. Guy's had the best of the remaining play till half-time.

On resuming, Guy's took up the attack, and this half was noticeable for sound play on the part of all our players. Peall and Camps made good runs and centres, but ill-luck seemed to dog us in front of goal. Bart's. forwards made several rapid runs down the ground, and Heap was called on several times. Three minutes from time an exciting attack on the Bart's. goal took place, and after their goal-keeper had twice saved, Rust put on our third goal. There was no more scoring, and Guy's won an exciting game by 3 goals to 2.

All our men played well, but Langdale was particularly noticeable for his tricky play forward. Hilton's dash was also conspicuous. Smith was best of the halves; Greenfield working hard but being rather slow. The backs were weak at the start, but were all that could be desired in the second half. Heap in goal played a safe game. Team:—

Guy's.—E. T. Heap (goal); V. C. Bent, J. Matthews (backs); A. H. Smith, D. G. Greenfield, P. P. Cole (halves); —. Camps, —. Langdale, C. T. Hilton, B. Rust. P. A. Peall (forwards).

From the Gazette's Special Pathologist.

O. R. T., St. Leonards.—Reaction, acid. Sp. gr. 1033. Albumen, a fair amount. Blood, *vide infra*. Sugar, considerable amount. Microscopical examination: This urine contains a fair amount of pus. In the centrifugalized deposit with the pus cells is a small number of blood discs. There are some crystals of calcic oxalate, some of which are grouped together in microscopic masses. No casts were found.

M.L.O., Mansfield.—The growth on blood serum after incubation consists chiefly of the streptococcus, var, longus, and some staphylococci. The Klebs-Löffler bacillus was not found. PATHOLOGIST.

Birth.

SHADWELL.—On March 9th the wife of St. Clair B. Shadwell, M.D., Lynhurst, Walthamstow, of a son.

Marriage.

MORICE—SEDDON.—On November 29th, at St. Paul's Pro-Cathedral, Wellington, New Zealand, by the Right Rev. Bishop Julius, assisted by the Revs. W. S. Bean and G. F. Waters, Charles G. F. Morice, F.R.C.S. Edin., son of Charles Lloyd Morice, Surgeon, of Greymouth, to Louisa, third daughter of the Right Hon. R. J. Seddon, P.C., LL.D., Premier of New Zealand.

Death.

HOWE.—On March 10th, at Bank House, Croxton, Preston, Douglas Redfern, fourth and youngest son of Joseph Duncan Howe, aged 8 months.

Ed.—H. L. E.

Contents.

	PAGE
BURNS AND SCALDS: Paper by Mr. F. E. Walker	161-170
PRIZES	170
PASSIM	171-172
CORONER'S INQUESTS	172-173
HOSPITAL NEWS	173-174
CHAPEL NEWS	174
NURSING NEWS	174
PAPERS BY GUY'S MEN	174
CORRESPONDENCE: Trendelenburg's Position in Abdominal Surgery; The Donations for the Central Panel of the Reredos in Chapel; A Grievance; More Grievances...	175-176
THE DISPENSARY REPORT FOR 1899	176-177
INQUESTS	177-178
SPORT: Football—Rugby: Review of the Season 1898-99; Summary of 4th XV. Matches. Association: Review of the Season—1st XI., 2nd XI; Guy's Hospital Lawn Tennis Club	178-180
APPOINTMENTS	180

Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well a subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

The charge for binding in blue, with the Arms of the Hospital in gold will be ONE SHILLING AND SIXPENCE.

Calendar of Coming Events.

April, 1899.

Sat. 22.—1.15 p.m. Clinical lecture by Dr. Perry.

Messrs. Lucas and Lane's take-in; Drs., J. C. J. Da Silva and J. S. S. Perkins; Cl., J. T. Dunston.

Mon. 24.—Third and Final M.B. Durham Exam. begins.

Tues. 25.—Cambridge Third M.B. Exam. begins.

Wed. 26.—Messrs. Golding-Bird and Dunn's take-in; Drs. A. M. Barron and E. Stott; Cl., W. L. Baker.

May.

Mon. 1.—Summer Session begins.

Final M.B. Lond. Exam. begins.

Reports for Bredin Prize for Clinical Study to be sent to the Dean by this date.

Wed. 3.—Messrs. Howse and Jacobson's take-in; Drs., T. T Kelly and J. E. L. Bates; Cl., G. N. Meachen.

9 a.m. Dr. Washbourn lectures on Bacteriology.

1.30 p.m. Clinical lecture by Mr. Jacobson.

Fri. 5.—9 a.m. Dr. Washbourn lectures on Bacteriology.

Sat. 6.—1.15 p.m. Clinical lecture by Dr. Perry.

Guy's Hospital Gazette,

APRIL 22, 1899.

Burns and Scalds.

A paper read before the Physical Society on Saturday, February 4th, 1899, by Mr. F. E. WALKER.

Mr. CHAIRMAN, PRESIDENTS, AND GENTLEMEN,—For choosing such a prosy subject as "Burns and Scalds" for a paper to be read before this Society, coming as it does after a series of brilliant treatises on some of the rare and interesting forms of disease, I ought, perhaps, to begin with an apology, or at any rate with a plea of justification. But there are so many obvious reasons why the consideration of these accidents should be peculiarly interesting and deserving of the attention of the general public, as well as of ourselves, that I think I need hardly do either. For injuries of this kind happen where surgical assistance and hospital treatment cannot always be immediately obtained; where the method of treatment does not require the exercise of much manual dexterity; and what is still more important, the appropriate means are beneficial in proportion to their timely application. No accidents are in themselves more terrible; and it is probable that none excite in the sufferer such immediate and serious alarm; nor are there any productive of more fatal consequences, especially when they occur in infancy and old age. It would have been thought that such terribly fatal accidents would, by this time, have been met by a course of treatment which would have reduced to some extent the disproportionate length of the death roll; but the words of Sir James Earle, spoken at St. Bartholomew's in 1832, are almost as true to-day as they were then. He said, "There are few accidents or maladies to which mankind are subject, which have met with a greater variety of treatment than Burns and Scalds; and as it appears to me, these methods have in general been received and adopted as things of course, and have been handed down without any fixed principle or determined idea attached to them." The fact that a mixture of vaseline and boracic ointment, spread on lint, is so very generally known as burn dressing, to my mind only bears evidence of the truth of this statement.

The screaming child is hurried into the surgery wrapped usually in its natural filth and a dirty shawl. The dresser, hardworked to keep the surgery clear, bathes it rapidly with warm something or other, while the ward clerk dashes for the dressing, and as quickly as may be the infant is despatched to the ward. If it sleeps, well and good. If it cries it is given opium. Anyhow it is left—left with a huge, freshly-made, absorbing surface which greadily soaks up what is pressed upon it, usually dirt. The first man that labels that drawer, "Dressing for Superficial Burns—only to be used on absolutely clean surfaces," will be doing an untold service to the poor little wretches, who are too often only victims to that which some would call a vice, which under the name of "enterprise" has in Englishmen so often proved a virtue, namely, their natural curiosity.

I propose with your permission to give a short account of how in earlier times the members of our profession

treated this form of injury; then to give a brief summary of the cases admitted of recent years into this hospital, with a slight digression on the pathology of shock and duodenal ulceration in burns; then to mention the complications most commonly met with in these cases, and finally to discuss their treatment.

In a country like ours, in which mining and manufacturing form such an important branch of the national industries, the question of the treatment of burns must necessarily be one of considerable importance, and it is not surprising to find that there is a very fair amount of literature on the subject. One of the most interesting and important works on the subject is an elaborate essay written by one Edward Kentish, of Newcastle, whose experiences and practice in the heart of the mining country, led him to work especially with a view to improving the treatment of this form of injury. His first "Essay on Burns" was published towards the end of the last century, and in it he reviews all the previous works on the subject that he could lay his hands on. His opening words are worth quoting:—"In showing the contradictory opinions of physicians and surgeons ancient and modern on the treatment of burns, nothing can tend to give us a clearer idea of the imperfection of our knowledge, than to collect those maintained by the most enlightened medical characters. As every succeeding investigator has a right to canvas the opinions of his predecessors, I shall profit of this right, not to cavil at them, but merely to show that when physicians and surgeons, who have seen some laws of the animal economy more clearly than their brethren, are not content with marking the information or giving a simple fact to posterity, but are eager to overturn the usually received and give us a new system, a great many errors creep into their works." There are very few branches of medical and surgical research to which at the present day these words could not be applied with equal truth.

Heister, in his Elements of Surgery, appears to have been the first to attempt to classify burns into degrees, according to their severity, and he made out four classes, and from his study of these concluded that they very nearly resembled inflammations, both in appearance and in their methods of cure. He advocated two methods of treatment, the application of astringents and emollients, though what guided him as to which remedy to apply he does not state. His astringents were such things as common spirit (dipping the injured parts into it), the liquor of pickled cabbage, vinegar and water with salt, applied hot, or the direct and immediate exposure of the burnt part to the candle or to the fire, as he said, "to hold it so exposed as near and as long as the pain will allow, till the sensation of heat and pain is abated. For thus not only the stagnated blood is, by the vehemence of the fire alone, reduced to its former state, but blisters also, with other severe symptoms, are most effectually prevented; and the first degree of burn thus without difficulty cured." How very simple it all seems. His emollient treatment is also interesting. For this he used moderately heated water, water in which quince seeds, linseed, etc., had been boiled, or as he says, "any other obvious poultice, and by the application of these whatever is contracted and wrinkled up in the fibres and small vessels of the injured part is softened, and the natural passage and circulation of the blood through them is restored and thus fatal consequences easily obviated." If the burns were more severe and affected a large surface of the body, he said it was necessary in order to guard against exulceration, ugly scars, and even gangrene, to take blood in proportion to the degree of burn, in some cases even to fainting, and afterwards to prescribe strong purging medicines. One is inclined to wonder whether that "afterwards" ever arrived. Kentish, in criticising this treatment, lets fall some very sound remarks. He says:—"Can we hesitate in saying he (Heister) had not had an opportunity of properly appreciating the merits of the different methods he recommends—for I have too great a respect for the heart of so enlightened a head, as to suppose he would either wish to lead into error or record an untruth. It falls to the lot of few men to appreciate properly the effect of the various modes of treatment in a particular disease; for if a patient recovers (whatever was the treatment, whether good or bad), we flatter ourselves it was the effect of our superior merit in conducting the disease; but future experience may convince us that the recovery of which we so vainly boasted, was, in reality, but a victory of Nature over the malpractice of art."

Van Swieten in his Commentaries on Bœrhave's Aphorisms has a good deal to say on the subject of burns. In describing the destruction of tissue resulting from this form of injury, and how it varies with the nature of the part affected, he gives as an example the smiths of the Hague, who could hold live coals in their hands for considerable periods of time, but whom a burn in any other part affected very severely. He gives a quaint description of an accident that befel one of these men that was followed by necrosis of the hard palate. This is his description:—"When this fellow was blowing with his mouth into a musket, the piece being charged, unfortunately took fire, he not knowing it was loaded, and by this accident his palate, gula, gums, and tongue, were miserably burnt up, inasmuch that he was not able to swallow anything for the space of eighteen days, though bleeding and other select remedies were tried, and the dead parts separated from the living; which being extremely painful and sore created much misery to the patient, till at length some fragments of bone being separated from the palate, he did well, and gained the better of death after a hard struggle."

Van Swieten recommended bleeding and what he called "antiphlogistic purges" for severe burns, and he relates how Hildanus cured a man who fell into a copper full of boiling dye by blood-letting, and the application of the best topical remedies. All these old time surgeons seemed firmly to believe in the efficacy of heat itself applied to the burnt part, in drawing or driving out the latent fire

concealed within, and which was causing as they supposed all the pain and destruction of tissue. Aristotle recommended it on the well-known principal of the sun's rays extinguishing an ordinary fire. The idea was prevalent, too, in the 16th century, Shakespeare himself evidently holding with it, for he makes Cardinal Pandulph say to King Philip in his play "King John"

'Fire cools fire
Within the scorched veins of those new burnt.'

and I have been assured that the belief in this method of treatment is still widely prevalent, especially among the lower classes.

If the injured part happened to be the face, purgation and bleeding alone were relied on. Bœrhave himself was once badly scalded on the face by the bursting of a Papin's Digester. His cheeks and eyelids so swelled up insomuch that he could not distinguish the light of a candle. He immediately ordered himself to be bled *ad deliquium*, and the next day caused the phlebotomy to be repeated, and afterwards took a very thorough purge, even though he was reduced nearly to a state of fainting by the weaker purges. After these profuse evacuations the tumour of the parts subsided, and by the use of a thin diet and plentiful drink of cooling liquors at the same time, the cure of this dangerous scald was so happily advanced, that after eight or nine day's time he appeared again in public with his eyes saved from so great a danger and for the great benefit of mankind in general.

Coming to later times, Bell, of Edinburgh in 1798 published his own observations on the subject, which contained one or two novel and noteworthy statements, but he made the same mistake of copying indiscriminately from other men's works without himself confirming their deductions. He makes the astounding statement that "a considerable degree of ease may be procured by plunging the injured part suddenly into boiling water, or any other fluid of an equal degree of heat. He goes on to say that one of the best applications for any burn is strong brandy or other ardent spirit. It seems to induce a momentary additional pain but this soon subsides and is succeeded by agreeable and soothing sensations. Possibly his patients applied it internally. Kentish says, "From all this, it will appear that though we are advanced in the circle of time, yet in the matter of treatment we are still where our ancestors left us."

On the Continent at that time, treatment was much about the same. In a work by M. de la Roche, a physician to a regiment of Swiss Guards (1791), Bell's descriptions are translated almost word for word. But his is the first work to contain any mention of opium, and this fact alone redeems it from unimportance. He, too, advocated the puncturing of the blebs without removing the epidermis, a method still considered quite sound, and he first advised the application of equal parts of lime water and linseed oil—the famous Carron oil—which has remained popular for a whole century, and which is still used at some of the London hospitals.

M. Fourcroy, in a work published a few years later, sagely remarked that the multiplicity of means used to cure burns proved that none of them had any power, and after ridiculing the ancients for believing that in order to effect a cure it was only necessary to extract the empyreuma fixed in the burnt part, he, himself, propounded the theory that Nature should be left to do her own work.

Diermerbroeck, a Dutchman, was decidedly more original. He was a gentleman who used to make his own ink, which he did apparently in very large quantities, for the purpose, I suppose, of recording his many and interesting observations. When called to any case of burn, he would post off his servant to fetch a large stone bottle of this ink, into which he made the patient plunge the injured member and keep it there for half an hour, after which he says, "The heat and pain were dissipated, nor were there any blisters formed or other ill consequences." If he had not sufficient ink on hand for the purpose, he used street mud as a substitute, and an Italian disciple of his, by name Panarole, gallantly backing up his master, recommended that if "mud could not be found"—he evidently never lived in the Borough—"it should be made artificially by mixing water and street dust, or the sweepings of houses." No wonder tetanus was common in those days. It was this same man that revived the treatment originally advocated by Fallopius—of tube fame—of using onion poultices.

Fabricius Hildanus, who also believed in the onion treatment, added to them white Venice soap, oil of sweet almonds and oil of roses, presumably an attempt to modify their natural odour. His wife, while doing the family cooking, imprudently plunged her hands into some boiling wine. The wine was upset, burning her severely, and besides suffering its loss, Hildanus tried his patent burn remedies on her. However, after what seems to have been a tedious illness, she ultimately got well.

With Kentish began a new era in the treatment of burns, for he was the first to knock on the head the practice, which seemed to have acquired a sanctity by age, of vigorous bleeding and purging. He says:—"I hope I have shown by observations taken from actual attendance on a great number of cases, that to bleed and otherwise debilitate the patient by what is called the antephlogistic regimen, while he is suffering acutely, is a plan pregnant with most dangerous consequences. To do this is one of my great objects, and if I can do it with half the energy I feel it, I have no doubt it will answer the purpose I intend."

The local treatment advocated by Kentish, though nothing very startling in character, was equally sound. Without exposing the patient more than was absolutely necessary, he bathed the injured part clean with warm water, making a great point of cleaning the surrounding skin, whether it appeared injured or no. He then applied large lint plasters, soaked in rectified spirit and yellow basilicon and spirits of turpentine, and he changed the dressings as little as possible, because he thought that

the very quick evaporation that took place during the first twenty-four hours was extremely pernicious; and whenever he did re-dress, he always had his plasters ready spread, the old ones being taken off one at a time and a new one at once applied. He supported the patient by alcohol internally, with opium if required, and made no restriction of diet unless fever was very marked. If the burns were very foul, he used cataplasms and bathed with warm Goulard water.

When we consider the average present-day treatment of a burn, I think we will agree that this man Kentish, even with all his quaint phraseology, would be no disgrace to modern surgery, could he now be planted down in our midst. He would be just the man we want to make numerous and important excursions from the set groove in which we are, at the present time, in great danger of remaining.

A man named Dickenson tried, some twenty years later, to pour cold water upon Kentish and all his works, pointing out with much and obvious animosity that Kentish's evidence adduced to demonstrate the pernicious effects of the so-called anti-phlogistic treatment, was based on insufficient grounds, and that his internal stimulant practice appeared to have entirely failed. Kentish's arguments may have contained certain fallacies, but no one can deny that the most important test of all—that of time and experience—has more than vindicated his conclusions.

Sir James Earle in 1832, strongly advocated the local application of cold, a form of treatment that was originally introduced in the time of Rhazes and Avicenna. He applied ice poultices and scraped potatoes. In his two lectures on Burns, he pays a well deserved tribute to Kentish's work saying "We are indebted to him for many useful suggestions. An experienced man unprejudiced by favourite theories will easily abstract the good and practical points, while he may smile at the ingenious and amusing hypotheses which are built upon them, and I must express my individual gratitude to him for the benefits he has conferred upon mankind."

Leaving now this part of the subject, and considering the subject of burns and scalds from a modern point of view, and with the special object of ascertaining the best methods of treatment open to us, it is, I think, quite unnecessary for me to repeat here what everyone already knows about this form of injury. So I will attempt no definition nor description of the naked-eye appearances, general effects and so forth, of burns and scalds. Dupuytren's classification, too, of burns into six degrees is so universally used that I need mention it only for completeness sake. It seemed to me, regarding the subject from a hospital student's point of view, that the best way to study the subject, would be to ascertain and set out the chief features of the cases of burns and scalds as met with in the practice of this hospital; and in order to do this, I looked up and very briefly abstracted the reports of all the cases admitted during the four years 1894–97, and for the purpose of comparison, those of burns admitted twenty years previously during the years 1874–77. Altogether I read close upon 400 reports, and very fine reports some of them were. And here, before giving a brief summary of them, I may perhaps be permitted to pay a slight tribute to the present-day ward-clerk. The standard of report writing now reached, is infinitely higher than it was twenty years ago. Perhaps this applies rather less forcibly to reports of burns, as to reports of other cases, for even now a burn does not often get a strikingly good report; in those days it was extremely lucky if it got a bad one. Though bad, however, some of them were very amusing. May I just quote one as an example. The following is practically the whole of one report:—

Ignatius C., æt. 4, was admitted in 1875 into Cornelius, under Mr. Birkett, and was in for over six months.

History of accident.—While sitting by the fire a cinder popped out and fell on his chest.

On admission (July 27th) he was found to be burnt on his back and buttocks.

July 28th. Bowels not opened.
29th. Bowels irregular.
Aug. 1st. Bowels still irregular. Have not yet been opened since admission.
10th. Carbolic oil used for dressing burns.
17th. Water very black. Carron oil substituted for carbolic.
26th. Healing very slowly indeed—the burns often bleed.
28th. (New Ward Clerk.) Beginning to heal quickly. Discharge less.
Sept. 28th. Wound now discharges a great deal and is rather offensive.
Nov. 9th. Child has been very unwell, suffering from general dropsy with dusky urine and albumen.
Dec. 19th. (Entries very scarce). Smells very much about the buttocks.
Jan. 4th. Fell out of bed yesterday and broke the wounds. They bled very much.
Feb. 5th. (Last entry). Going on well.
Mar. 1st. Left the hospital.

But every report did not bristle with good points as did this one. In others they were only few and far between. One child, for instance, merely suffered from "a very great number of multiple blebs." In the older reports, "healthy discharge" was very common. In one the clerk records that "Mr. Cooper Forster said that the fœtor arising from the seat of injury was enough to give the whole ward erysipelas;" so the child was promptly transferred to another one in the medical building.

Another worthy ward clerk, after leaving the report severely alone for nearly three weeks, remarks, "The wound continues to be redressed, but there is nothing worth noticing other than what one would expect." And yet we are told that it is the unexpected that always happens.

I must now crave your permission to afflict you with a few figures. They shall be as briefly stated as possible. During the four years 1894–5–6–7, 224 cases of burns

and scalds were admitted into this hospital. Of these, 80, or over 35 per cent., died—one in three. Compared with the four years 1874–77, this is a marked increase in the mortality, when the figures read 122 cases admitted, 33 deaths—only 27 per cent. Burns were nearly twice as numerous as scalds, or more exactly in proportion of seven to four. Of the 80 deaths, over three-quarters were due to burns, 17 only from scalds. Of the 224 cases, 133, or nearly 60 per cent., occurred in children under five years of age. As regards sex, five out of every nine were girls—inquisitiveness again, I suppose. The average length of stay of each case for the four years works out at exactly 18 days. The corresponding figure for 1874–77 was 44 days. This on the face of it seems a great improvement. It must be remembered, however, that these figures include all cases, amongst them those dying within a few hours of admission. Taking into consideration that the number of burns admitted of late years greatly exceeds that of former years—due partly, perhaps, to the increasing popularity of the district, and the almost universal use at the present day of cheap paraffin lamps among the lower classes—the disproportion between these figures becomes less marked. Still, even with the liberal discount which these considerations demand, it is obvious that the whole difference has not been accounted for; and so we must conclude that with the more general use of antiseptic methods, the period of convalescence in those cases which do not succumb to the initial shock or succeeding collapse, has been very considerably shortened.

The causes of these forms of injury, as met with in hospital patients, are too well known to call for much notice. I have already mentioned that burns occur nearly twice as often as scalds. Of these burns nearly a third are definitely reported as due to accidents with oil lamps—a proportion surely sufficient to call for legislative interference. Nine epileptics were admitted during 1874–77, and five during 1894–97, burnt owing to and during the progress of a fit. Gas explosions were responsible for seven of the 224 cases. Nearly the whole of the remainder were due to clothes being ignited by the fire on the hearth. One little girl got her injury by a pathetically comic misfortune. She picked up the paraffin can, and her mother, believing her to have swallowed some of the contents, promptly gave her a stiff dose of brandy. Subsequent unsteadiness caused the child to stumble into the fireplace; however, she ultimately got well.

As regards the actual cause of death in cases of burns and scalds, it can be well understood that shock and collapse claim most victims. Of the 80 fatal cases during 1894–97, 69 died within five days of the accident, 46 of them within twenty-four hours. This leaves only 11 to be otherwise accounted for. Of these 7 died with marked symptoms of septic absorption, one of erysipelas, one died in a fit, ? uræmic, two from broncho-pneumonia, probably septic in origin. Of the 69 that died within five days, two are signed up as dying of their broncho-pneumonia, and two of their hyperpyrexia. I shall shortly allude to the question as to whether there are grounds for the theory that shock and collapse may be septic in origin.

The effects on the body generally may be considered under the headings—

(1.) Shock and collapse.

(2.) Reaction and inflammation, under which heading comes the majority of the cases of hyperpyrexia observed in burns.

(3.) Various local and general conditions due in most instances to bacterial invasions. These include ulceration, sloughing, lymphangitis, abscess, cellulitis, septicæmia, pyæmia, hæmorrhage, etc. In a case treated from the beginning such complications ought never to occur.

(4.) Other complications.

Considering for a few minutes the subject of shock and collapse. Considerable doubt appears to exist as to what is included under the term shock and what under collapse. The two words are often used as if they were synonymous and interchangeable. Shock, we are told, is a condition of sudden depression of the whole of the functions of the body, due to powerful impressions upon the system by physical injury or mental emotion. Its more obvious manifestations are signs of lowered activity of the cardiac, respiratory and sensory functions. A state of prostration very similar to this, but affecting those suffering from disease, from the more remote effects of injury, and from the effects of certain poisons, is known as collapse. The pathology of these states having been imperfectly understood, the distinction between them has hitherto rested upon the differences in the conditions under which they occur. Although emotional disturbance alone may cause shock, the state more usually follows a severe bodily injury, such as a severe burn, or a less severe injury of an important organ.

Thus they are two states of prostration similar in their outward manifestations, and both mainly dependent upon failure of the circulation, but differing essentially in the pathological changes which cause the circulation to fail. The causes of shock are such as may be expected to produce an effect upon the central nervous system, either directly or by means of afferent nervous impulses. Collapse, on the other hand, usually occurs in that class of injuries or diseases in which there is considerable escape of fluid from the blood of the injured tissues, such as in cholera, after abdominal operations, and in those diseases in which diarrhœa and vomiting form prominent features. In none of these conditions is there any reason to think that the central nervous system is greatly affected. Certain poisons, however, cause a condition of prostration which is usually known as collapse, and some of them certainly appear to act upon the circulation (either directly on the heart, or indirectly through the nervous system) to such a degree as to come under the definition of shock rather than collapse. The others, however, act locally upon the wall of the alimentary

canal, and by causing diarrhœa and vomiting lead to thickening of the blood, and therefore may be included under the heading of collapse.

Considering, then, shock and collapse with burns and scalds as the primary cause, it would appear that shock is the more important condition; for the nature of the injury, with its extensive irritation or destruction of nerve endings, is such as to induce the condition in its most typical form. There are, however, certain ways in which collapse as above defined may occur after this form of injury, and it will of necessity be, as a rule, a complication later in its onset than shock. Immediate hæmorrhage from a burn is extremely rare, if it ever occurs at all. There is no mention of even slight hæmorrhage in all the reports that I have looked through, and obviously the nature of the injury is such as to prevent this catastrophe, for do we not use the cautery for the purpose of stopping hæmorrhage. Secondary hæmorrhage—I am speaking now of bleeding at the site of injury—is more common, and used to be still more so when profuse suppuration was looked upon as Nature's method of washing out the irritating poison.

Suppuration and hæmorrhage, then, are possible causes of collapse in burns, but at the present day it would mean culpable negligence on the part of someone or other if it was allowed to occur. Diarrhœa and vomiting, however, are less preventable causes of collapse. Possibly they depend on the absorption of some poison manufactured at the seat of the lesion, an auto-intoxication. Certain it is that they are both very fatal complications of the already very serious injury. I will mention these again later. There is a fourth way in which collapse may occur in cases of burns. Sherrington and Copeman showed conclusively by means of experiments detailed in Clifford Allbutt's System of Medicine, that collapse is almost invariably accompanied by, and seems to depend on the appropriation by some part of the body of a large quantity of fluid from the blood, a consequent rise in its specific gravity, and a subsequent withdrawal of fluid from the solid tissues to take or partly to take its place. The specific gravity of the injured tissues immediately surrounding the seat of burn markedly diminishes, while that of the sound tissues in more remote parts of the body correspondingly increases. So long as blood loss to the injured tissues is compensated by blood gain from the sound tissue, the circulation remains undisturbed, and collapse is averted, but when the moment arrives that the reserve of fluid in the uninjured tissues is exhausted, the circulation begins to be retarded and after some hours to fail, accompanied with the phenomena of collapse. And this explains the fact that collapse, unlike shock, comes on insidiously, not suddenly, and often many hours after the receipt of the injury. To substantiate this theory, namely, that inflammatory œdema was the cause of collapse in burns and scalds, Sherrington in 1894 conducted experiments in which he immersed the hind limbs of animals in hot water for several minutes, full anæsthesia being maintained, and the nerves of the limb divided, to prevent subsequent pain, this preventing at the same time the circulation from being affected by reflex action. The scalds were followed by marked rise in the specific gravity of the blood which lasted for some days, collapse ultimately supervening in the severer cases.

If this, then, is the true nature of the pathological changes that occur, intravenous injection of salt solution would appear to be the ideal treatment for collapse after burns. For some reason or other, however, in practice it is found to produce only a temporary improvement, and in the three cases that I have come across in which it was performed after burns, no permanent success attended the treatment, but all proved ultimately fatal.

The symptoms of shock are so well known that I need not here enumerate them. One cannot judge much of the patient's condition by the mere feeling of the pulse, but it is usually irregular and rapid, and the breathing is still less trustworthy. According to Dr. Louis Cobbett, it is accelerated and irregular, but according to Sir William MacCormac it is remarkably slow and irregular. Shock occurring in burns often differs, however, from shock as seen under other conditions, in that the onset is delayed for some time, often hours after the accident. The usual course of events is for shock to come on within half an hour or so, or sooner, except in those cases where the stimulus of excitement keeps up the activity of the nervous centres. But in burns, I have myself seen cases in which the symptoms of shock have not supervened until some hours after the receipt of the injury. Children arrive at the front surgery extensively burnt, yet with good regular pulses, perhaps 100-120—not very rapid for a child—neither cold nor pale, nor sweating, breathing a bit rapidly perhaps, certainly not slowly, and perfectly conscious. It is this period of lull before the storm, of comparative health before the supervention of shock, that I believe, should be seized upon, and made most use of if our burns are to be treated thoroughly, scientifically and successfully. "In extreme diseases, extreme methods of cure are most suitable," was one of Hippocrates' aphorisms, and our ill success hitherto in these terribly fatal cases may perhaps have only been due to our half-hearted thoroughness.

The pathology of shock following burns appears to be that afferent impulses arising from the injured area travel to the vasomotor centre in the medulla, and by means of impulses thence reflected, cause the arterioles of the body generally, and of the splanchnic area in particular to dilate, thus lowering the mean arterial blood pressure. In consequence of this, so large a quantity of blood accumulates in the abdominal veins, that the volume of blood passing through the rest of the body is seriously reduced. The anæmia of the superficial parts of the body which is produced in this way, seems to be accompanied by a diminution of lymph in these parts (as has been shown by Dr. Lazarus Barlow), and this may be a satisfactory explanation of the patients' pinched and sunken appearance, to which the name

Facies Hippocratica has been applied. Dilatation of the abdominal vessels does not, however, explain the entire phenomena of shock. M. Roger explains the rest of it by the theory that he considers proved, that there is an arrest of the normal vascular exchanges which leads also to a diminution in the production of heat, thus causing the fall of temperature which is found in all cases.

As regards the duration of shock, MacCormac gives it as from fifteen minutes to five or six hours or longer, and states that the more efficient the treatment, the shorter the duration. Watson Cheyne gives two to twenty hours, and at the end of that time reaction with increased temperature, an improved, though perhaps as rapid, a pulse. Many authorities state that vomiting is often one of the first signs of recovery from shock, but, as will be mentioned later, any vomiting whatever in a case of severe burn is an extremely bad symptom. The state known as prostration with excitement, which is described in many books as one of the terminations of shock, in which the respiration is hurried, the skin hot, the face flushed, and the patient remains half unconscious and perhaps delirious, seems to be nothing more than the onset of septic fever of the worst kind, acute in its onset, short, and invariably fatal in its course.

The theory has been advanced that a great part, if not the whole of the shock and collapse which almost always follows severe burns, is due to the absorption of some toxic body manufactured at the seat of the injury. The experiments of Vassalé and Sacchi show that the juices of burnt tissues are highly toxic, and Lockwood believes it probable that they contain a poisonous substance allied to muscarin. If this is so, then the condition is analagous to that produced in so-called ptomaine poisoning, poisons produced during the putrefaction generally of animal substances, and which resemble in their physiological action curare, digitalin, muscarin, atropin, strychnine, the various snake poisons, and others. Similar ptomaines have been obtained from pure cultures of the typhoid bacillus (typho toxin) from cholera cultures, and from tetanus cultures; and a crystalline alkaloid was obtained by Lever from pure cultures of the staphylococcus pyogenes aurens, which was capable of causing suppuration. The name toxalbumins has been given to this group of poisons, and the pathology of intoxication by them has been exhaustively set forth by Dr. Simon Flexner in last year's volume of the John Hopkins Hospital Reports.

As regards the hypothetical poison or poisons produced in burnt tissues, some have believed them to be unorganised ferments or enzymes, while others have endeavoured to prove that they are of a non-albuminous nature, but, whatever their character, their importance depends on their actual presence, and if pathologists will definitely assure us of this, then the aseptic and antiseptic treatment of burns will become doubly important; for of the eighty deaths from burns that occurred at this hospital, close upon sixty of them, or about three-quarters, were signed up as due to shock or collapse.

I will briefly describe the phenomena of ptomaine poisoning, which we can then compare with the condition produced by shock of burns. The onset is often sudden. There is usually a period of incubation varying from twelve to forty-eight hours, rarely longer. In about one case in three the first definite symptom is a sense of chilliness, usually with rigors, sometimes a cold sweat. Diarrhœa, vomiting and abdominal pain soon come on, cold sweating being nearly always present when the pain is very severe. Muscular weakness, headache, temperature rising in some cases to 101°, 103° or 104°. In some cases the skin feels actually cold. Pulse quick, averaging 128 in adults (in whom this illness is more usual). Other rare symptoms are cramps in the legs, muscular twitchings, general convulsions, drowsiness, pains in the joints, etc. In the fatal cases death is almost invariably preceded by collapse, like that of cholera, coldness of the surface, pinched features—the so-called "facies Hippocratica"—and blueness of the fingers and toes.

Now, when it is remembered that the symptoms just related usually result from poisonous food introduced into the stomach, it can well be understood that diarrhœa and vomiting are *ipso facto* likely to be the best marked symptoms. If, then, we discount to some degree the prominence of these symptoms, I think it will be agreed that the two conditions—that resulting from known ptomanine poisoning and that at present believed to be the result of shock in burns—have so many points in common as to justify the suggestion that the two conditions may possibly depend on similar causes.

Some authorities of the present day—Dr. Washbourn, I believe, among them—are rather sceptical as to the frequency of the occurrence of poisoning by ptomaines, believing that in most cases it is due to the actual presence of some micro-organism, but nearly all agree that though rare, there is such a thing as ptomaine poisoning not dependent upon microbes. If, however, this belief is ultimately disproved, and that form of disease is shown to always depend on some pathogenic organisms, assuming, for the moment, that the shock of burns is an analagous condition, then the outlook, as far as treatment is concerned, is perhaps even more hopeful.

Pursuing this subject a little further, I have mentioned that the poison said to be produced at the seat of burn is supposed by many to be of the nature of the unorganised ferments or enzymes. Now, Dr. Flexner has done a good deal of work with two toxalbumins—called ricin and abrin—which are believed by Stillwark to be themselves unorganised ferments. If, then, we study and compare the lesions experimentally produced by these poisons with those found post-mortem in cases of severe burns who have suffered from shock, we may get a little further evidence as to whether the poison alleged by Vassale and Sacchi to be present in the juices of burnt tissues is responsible for any of the pathological

conditions observed ante- and post-mortem. It may be mentioned that ricin and abrin are toxalbumins derived from the seeds of the castor plant and from the paternoster bean respectively. Ricin is believed to be a poison which acts primarily upon the blood, and its action is not limited to the blood of any one kind or class of animals, but has been found to extend to all vertebrates. Flexner used for his experiments (into the details of which I need not enter) rabbits, guinea-pigs and mice, injecting the poison subcutaneously or intravenously. The symptoms observed were rise of temperature some three degrees or so, then a gradual fall until death occurred. Great general weakness or convulsions occurred in some cases. Diarrhœa was always present, and the stools often contained blood.

The gross pathological lesions observed were punctiform hæmorrhages, most abundant in the peritoneal cavity, but also occurring under the pericardium and pleuræ. The peritoneal cavity often contained a great excess of fluid, sometimes hæmorrhagic. In the intestines, in which the fluid also presented a bloody aspect, serous hæmorrhages were very numerous. No gross lesions of the blood vessels were discovered anywhere. The lymphatic glands generally showed enlargement, and were soft, congested, and sometimes hæmorrhagic. One of the most striking features was the condition of the intestinal mucosa. In the case of very rapid death (six hours) the intestines were filled with opaque, almost fluid contents, much resembling cholera stools. The mucous membrane as a rule was pale, the patches of Peyer were much swollen, elevated, and of a dead white colour. In other cases the appearances were different; while the intestines were always distended, the contents were semi-fluid and tinged with blood, while the general surface of the mucosa was greatly congested and beset with pin-point patches. Peyer's patches were deeply congested. Although Kobert and Ehrlich found actual ulceration in some cases, Flexner did not.* The mucous membrane of the stomach was congested in all cases. In a few instances superficial losses of substance in the mucosa were noted. Around these, all signs of reaction were missed. In one rabbit there existed in the stomach a congested patch the size of a quarter-of-a-dollar † (Flexner is an American), over which the epithelium was entirely necrotic. The spleen was uniformly swollen and softer than normal. The liver showed some hæmorrhages. The heart showed no gross lesion, the right side was filled with blood. The kidneys were normal. The duodenum was not found to be affected to any worse extent than the rest of the small intestines. The stomach was, on an average, affected to a distinctly less degree than the intestinal tract. Dr. Berkley has shown that in animals poisoned by these drugs, inflammatory changes in the central and peripheral nervous systems occur. That the injected toxalbumens are eliminated principally by the gastro-intestinal tract, the appearances at autopsy left no reasonable doubt. Moreover, the poisons themselves were actually found in the semi-fluid mucilaginous contents of the intestine.

Turning now to consider the conditions of the internal organs which have been found (post-mortem) to occur in burns, Lockwood says that in a small proportion of cases of burns or scalds, small hæmorrhages, acute inflammations or ulcerations are found in the intestinal tract. He quotes the post-mortem records of St. Bartholomew's Hospital, and says that during the ten years 1884–93, 138 patients died from burns or scalds, and he could only find three post-mortem records of pathological changes in the alimentary tract, but he does not state whether inspections were made of all the cases that died. In one case there were found small submucous hæmorrhages the size of a pin's head at the pyloric end of the stomach, in the duodenum, and in the cæcum. In the case of a child, small punctiform hæmorrhages were found in the duodenum. In the third case there was acute inflammation and ulceration of the mucous membrane of the duodenum after an extensive scald of the chest. Other lesions found are acute nephritis, but this is rare. Pleurisy and pneumonia are frequent. Their presence may be unsuspected before death. Engorgement of the vessels of the meninges is occasionally observed. Cardiac thrombosis is mentioned by Brown as an occasional cause of death, and Zenker's degeneration of muscle has been noticed.

Turning now to our own records. As I have stated, 80 deaths have occurred during the four years 1894—1897. I could find only 14 post-mortem records of inspections made on cases of burns during that time. This number was clearly far too small on which to base any theories; so I examined the records for the last twelve years and found the reports of 74 inspections. Although this number is really too small to be of very much value, still I give the facts that I learnt for what they are worth. Of the 74 cases, 42 died within a week of admission—I mention this especially for this covers the greater number of cases that were signed up as dying from shock or collapse. Of the total 74 cases, 28 showed either ecchymosis, congestion, early inflammation, or (as in one case) marked ulceration of the alimentary canal. That is about in two out of every five cases. In 10 cases there were sub-serous (pleural or pericardial) petechial hæmorrhages. Bronchitis or broncho-pneumonia was found in 18. Œdema or partial collapse of the lungs in 12. Rashes (presumably septic in origin) were noticed in six cases. As to the actual parts of the alimentary canal affected in the 28 cases, the stomach was affected in 13, the duodenum in 11, and the rest of the intestine also in 11 instances. A large and soft spleen was observed four times. The kidneys were congested in a like number, and the lymphatic glands were twice noticed to be generally enlarged. A few other odd morbid conditions are recorded, evidently only coincidences. In one case the right adrenal body showed a large hæmorrhage, in another the stomach was mammillated. Two women

*He, however, observed free desquamation of necrotic epithelial elements which with fragmented cells were piled up on the surface of the mucous membrane. Under the microscope there was found to be no thrombosis of the blood vessels (Zenker's fluid was used to perfectly preserve the blood).

† Equal in size to a shilling.—Ed.

had double hydro-salpinx. One man had a direct communication between his gall-bladder and colon. Two cases had abnormal diverticula of the alimentary canals, one of the duodenum, and the other of his œsophagus. This last man was interesting: he was in Cornelius under Mr. Durham in 1891. He had a circumferential pressure mark round his 75-ounce liver, and was also afflicted with precisely the same name as my own. He *died of melancholia*. One woman besides her burn suffered from obsolescent phthisis.

Comparing, then, these conditions with those observed by Flexner and others after death from toxalbumins, the morbid changes which have been seen in both conditions are:—congestion, inflammation, and rarely ulceration of the alimentary tract. Petechial, subserous hæmorrhages. Large soft spleen and enlarged lymphatic glands. As I have just stated, in 28 out of 74 inspections, lesions of the alimentary tract were observed. Two of these showed general enlargement of lymphatic glands. In ten cases subserous hæmorrhages were seen; in most of these, their distribution was fairly extensive. Of these ten cases, three showed lesions of the alimentary tract as well. And of the seven others, two had enlarged and soft spleens. So that altogether it may fairly be said that 35 of the 74 showed lesions compatible with the theory that they may have died of toxic absorption. Of these 35, 24 died within seven days of their accidents, and are signed up as having died of shock or collapse. On reading through the reports of these cases, in four of them there does not seem much evidence that what we at present understand by shock was the actual cause of death, but it was rather from hyperpyrexia apparently due to septic absorption. Anyhow there are 20, and possibly more than 20 of the 74 cases which, in the absence of any burn, would have done very well for cases of death from ptomaine poisoning. I will not press this point further, for there are so many considerations which have to be taken into account, and which I have not had the time to discuss fully; but I merely throw out the suggestion that there seems to be a good deal more evidence than is generally thought in favour of this toxic theory.*

And this leads to the consideration of the question of duodenal ulcers in burns, and I cannot do better than transcribe what the man who first called attention to the phenomenon wrote originally in the Transactions of the Medico-Chirurgical Societies in 1842. Curling was at the time assistant surgeon at the London Hospital, and his paper, in which he recorded ten cases, was one on Acute Ulceration of the Duodenum in Cases of Burn. He believed that the occurrence of these cases, considering the rarity of ulceration of that part of the alimentary canal, and the absence of previous intestinal affection, sufficiently indicated the existence of connection between injury to the skin and disease of the duodenum. It was Dupuytren who first noticed the circumstance of congestion in the mucous membrane of the alimentary canal, in common with a similar condition of the blood vessels in the brain and lungs, and of the stomach and intestines being subject to inflammation after recovery from the immediate effects of the injury; but he did not definitely specify the duodenum as the particular seat of the lesions. Here is a moderate translation of his original writing:—

"If the patients, after having survived the first shock of the burn, die during the second stage, between the 3rd and 8th days, from the violence of the inflammatory reaction, after having shown during life all the symptoms of acute visceral inflammation, one finds post-mortem all the most characteristic signs of gastro-enteritis usually accompanied by an inflammatory condition of the brain and meninges. Also, if the patient does not die for some longer time, during the period of suppuration and exhaustion, one finds on the viscera, and above all in the alimentary canal itself, profound changes which indicate a long-standing inflammation. The mucous membrane shows scattered spots of a more or less bright red colour, or somewhat broken up, and with superficial and deep ulcerations. The mesenteric ganglia are usually engorged."

Curling himself gives details of ten fatal cases in which actual ulceration was found, and of three others in which inflammation only of the alimentary tract without ulceration was observed. Of the ten cases of ulceration, six died of hæmorrhage into the alimentary canal; three perforated and died of peritonitis. All the cases but one, were under twenty years of age, the average being ten and a half. The burns, in most of the cases, were very extensive, but in one, only involved the front of the chest. In this case death did not occur until five weeks had elapsed from the time of injury, and two from the time that blood was first noticed in the stools. Death occurred in the other cases between the 5th and 18th day, the average working out at the 12th. The seat of ulceration was usually the first part of the duodenum from a quarter to two inches from the pylorus. In one instance the lesion was in the second portion. In six of the cases the pancreas was found adherent to the base, or actually forming the base of the ulcer, and Curling explained the profuse hæmorrhage from the involvement of the superior pancreatico-duodenal artery. In discussing the causation of the inflammatory changes, he suggested that it was an effect of the sudden arrest of the skin functions. He described minutely the glands of Brunner, stating that though their office and nature and the uses of their secretion had not been well ascertained, yet their number and size indicated a by no means unimportant function. He thought that the stoppage of the secretion of the skin glands caused sympathetic increased action of Brunner's glands and the irritation thereof lead to inflammation and ulceration. He goes on very honestly to state that

* Since writing the above, I have read an article by Dr. Bardeen, in vol. vii. Johns Hopkins Hospital Reports. He also arrives at the conclusions that there is not sufficient evidence for us to accept the old theories as to the causation of death after extensive burns, viz., that it is due to vaso-motor changes, or to extensive thrombosis, or to the influence of the burning on the internal organs. He concludes that acute toxæmia is the real and ultimate cause, although he admits that the nature of the toxic bodies and their mode of action and origin are matters of conjecture.

this hint concerning Brunner's glands he owed to Bowman, of King's College.

Hodgkin was inclined to believe that the severe vomiting that was very often noticed to precede the fatal hæmorrhage was, by the straining and traction, a sufficient cause for the ulceration. He was the first to minutely describe the characters of the ulcer. Against this theory of vomiting as the cause, it can be urged that the duodenum is nearly fixed and therefore not much disturbed by the act. Moreover, cases of ulceration have occurred in which vomiting had not even been present, and many where it was only slight. In his work on the subject, Hodgkin came across one case of a healed cicatrised ulcer of the duodenum in a woman who, some years previously, had had a severe burn.

Drs. Shaw and Perry, in their paper "Diseases of the Duodenum," Guy's Hospital Reports, 1893, discuss this pathological condition very fully. Wilks, in an earlier volume of the Reports had criticised Curling's views, and had quoted twelve consecutive post-mortems on burns showing no ulceration of any kind, and concluded that the subject was open to much more extended observation. The observation was promptly extended by Drs. Shaw and Perry. They analysed the post-mortem reports of Burns for the fifty years, 1843 to 1892, and found 149 cases. This did not include all the cases of burns dying in the hospital during those years, as it is not usual to inspect bodies of patients dying from burns unless they survive for several days. Ulceration was found in five cases only. To these they added Curling's ten cases, and 14 others from various sources, making 29 in all, and they compare Curling's ten with the other 19. The youngest of their cases was 4, the oldest 70 years of age. The duration of life in Curling's cases varied from 8 to 37 days; in theirs the earliest death took place 4½ days, the latest 75 days after the accident. In ten out of these 19 neither hæmorrhage nor perforation occurred. Of the remaining nine, one died from perforation, seven from hæmorrhage, and one from hæmorrhage and perforation. They admit an undoubted relationship between the cutaneous and intestinal lesion, for their statistics indicate that whilst of persons dying from all causes, ·4 per cent. only are found with duodenal ulceration, no less than 3·3 per cent. of those dying from burns exhibit this condition. All observers admit that congestion and ecchymosis of the alimentary canal as the result of burns is far more frequent than ulceration of the duodenum. In their opinion the theory of supposed "sympathy" between the burnt skin and Brunner's glands is so entirely unsupported by any physiological or pathological evidence that it may be disregarded. Dr. Hunter, in 1885, showed that by subcutaneous injection of certain poisons into dogs, an ecchymosed, and in some cases an ulcerated, condition of the duodenum could be produced, and he attributed it to the excretion of the poisons by the bile into that part of the gut. But Drs. Shaw and Perry ask that if this is so in the case of burns, how can the congestion, which undoubtedly occurs in all parts of the alimentary canal, including the stomach, be accounted for? They themselves incline to the view that the diffuse patchy congestion is the predisposing cause, and that the exciting cause of the ulceration is the digestive action of the gastric juice, and that the fact that the exciting cause can only exert its effect above the biliary papilla is a sufficient explanation of the almost invariable limitation of the ulceration to that part of the duodenum. The mode of production of ulcers associated with burns seemed to them to be identical with that of septic ulcers, and the ulceration due to the septic condition of the burnt surfaces. In support of this, they again quote their statistics. During these same fifty years just on 600 cases were inspected which presented some obviously septic or pyæmic condition. Of these 16 showed duodenal ulceration (1 in 37). In burns it was 1 in 30.

As to the position and character of the ulcers of the 29 cases—in 22 it was in the first part; in 4 in the second part; in 2 in the first and second parts; and in one the situation was not stated.

The ulcer is commonly deep, usually circular, varying in diameter from one-third to one and a half inches. Perforation or hæmorrhage occurred in 20. The average time of death from perforation was eleven days; from hæmorrhage fourteen and a half days. Clinical symptoms are usually absent until the passage of blood by mouth or per anum. Pain in the right hypochondrium or epigastrium with tenderness and vomiting were the most frequent.

(To be continued.)

Prizes.

The following Prizes and Certificates have been awarded:—

Golding-Bird Gold Medal and Scholarship.—Stanley Copley (Gold Medal and Scholarship of the value of £20); C. M. Vernon (Certificate); H. J. Spon (Certificate).

Senior Prizes for General Proficiency.—C. T. Hilton (First Prize, £20); E. B. Dowsett (Second Prize, £15); G. N. Meachen (Third Prize, £10); A. Reid (Certificate).

Junior Prizes for General Proficiency.—C. H. Robertson (First Prize, £20); J. T. Hicks (Second Prize, £15); A. E. H. Pakes and A. H. E. Wall (divide Third Prize, £10); P. P. Cole (Certificate).

Michael Harris Prize in Anatomy.—C. H. Robertson (Prize, £10); A. H. E. Wall (Certificate); W. G. Parker (Certificate); H. T. Palmer (Certificate).

Wooldridge Memorial Prize in Physiology.—J. T. Hicks and A. E. H. Pakes (divide Prize, £10); P. P. Cole and E. G. Goldie (Certificates).

(Signed) LAURISTON E. SHAW,
Dean.

Guy's Hospital,
April 12th, 1899.

Passim.

As Gazette after Gazette comes out, there is so monotonous a chronicle of the repairs, alterations and developments of the Hospital, that many who have left Guy's must think there is a foreman of the works at the Gazette office. As a matter of fact, the history of Guy's at the present time is a history of bricks and mortar. Wherever you turn there are workmen pulling down and building up, experts at the former pursuit, and every corner is full of building material. The whole scene is a paradise for the loafer and colonnade step talker, affording him a welcome topic of conversation and the inspiriting vision of other people busy.

This week one side of the Colonnade is pulled up to make way for Mr. Bonsor's gift of a mosaic pavement. To allay the fears of the more artistically minded, who feared an eruption in white and pale blue, we are able to announce that in contradistinction to ward floors, the Colonnade is to be laid down in white and black. The excavations have brought nothing remarkable to light save a few old pipes and a couple of early Georgian pennies. To the disappointment of the sensation monger, no bones have been found beneath the stones.

The Secretary of the Lawn Tennis Club has published an urgent appeal to all who are, or think they might be interested in tennis, to come forward and show themselves. As he most rightly says, with the exceptional number of courts at the disposal of the men, and the great facilities for practice, there ought to be some good tennis played at Guy's. But good tennis like good football or good cricket, is only achieved by the well worn methods, continual practice and keenness, both of which are sometimes to seek. As succeeding seasons come round, exhortation to this effect appears in these columns, whether it be in matter of cricket, football, or the aforesaid tennis, till everybody must be tired of our manuscript enthusiasm. We are justified in again crying aloud this year by the remarks of the Lawn Tennis Secretary, who styles the game up here as for the most part somewhat elementary. May he reap the reward of his own keenness by a successful season, and some elevation in the standard of the game.

Up to the present time, with great exercise of self-restraint, "l'affaire Dreyfus" has been rigidly excluded from these columns. We can, however, no longer keep silence, as a painful event of the greatest importance occurred this week within the walls of the hospital, an event evidently closely connected with the proceedings in Paris. On the morning after the disclosures of Col. Picquart's evidence in the *Figaro*, a sparrow was found in one of the trees in the park, hung by the neck beneath his own nest, dead, seemingly by his own hand. No incriminating documents were found, but the event has created a great sensation.

A new departure in the Nursing World of Guy's was made this year at the Matron's "At Home." For the first time there was a public distribution of prizes and medals to the nurses, the successful candidates being decorated by Mrs. Cosmo Bonsor. Now once started, it is proposed, if possible, to make the occasion an annual one. The nurses certainly well deserve the compliment of a public appreciation.

We have received a communication from Mr. Arthur J. Sharp, M.D., F.R.C.S., of Whitby, enclosing a Resolution moved by him and passed unanimously at the meeting of the Yorkshire Branch of the British Medical Association, held in Leeds on March 22nd, last. It is to this effect—"That this meeting feels that the time has now come when the general practitioners of the United Kingdom are entitled to demand a much larger share of direct representation in the General Medical Council." As this Gazette is the organ of the students at the hospital, the majority of whom are unqualified and not able to vote, much shouting by us would have little effect. But as the majority of these men will ultimately become general practitioners, the resolution should have, and has, the warmest appreciation from the Gazette. Probably many readers will remember Dr. Sharp as a clever and caustic contributor to these pages in former years; his great work was a plea for the scientific diagnosis of nervous disease, a paper in which he ran full tilt against many distinguished authorities within the walls of this hospital.

Nurses Nutt, Powell and Clarke have returned from their year's work on the Niger, and received a hearty welcome at Guy's. Though not quite broken down in health, the climate has made its mark upon them to a greater or less degree, and only one of them, Nurse Nutt we believe, thinks of going out again. We hope to publish in the next number of the

Gazette an account of their nursing experiences during a year's stay on the West Coast.

A correspondent draws our attention to what, if true, is a grave error on our part. His grievance is that the account of the Debate on the Ladies' Night as published in our columns is inaccurate, and that silver oratory was put into the mouth of Mr. Shufflebotham, where, according to our correspondent, it was not, at least not in the context as reported. We must apologise for the fault, and at the same time we must repudiate the insinuation that the Gazette in any way unjustly favours Mr. Shufflebotham. If the latter gentleman's speech is so much more fully reported than others it only shows what a great effect Mr. Shufflebotham's speech had upon our reporter.

A meeting of the Blues Committee was held on April 11th, and the following Blues were awarded:—Rugby Football Club, A. O'Brien, K. B. Trubshaw; Association Football Club, F. M. V. Smith, N. P. Shepherd, J. Matthews, G. M. Brydone, E. Norton, T. P. Manser, H. L. Dent.

Mr. A. W. Ormond has been appointed Ophthalmic Registrar in the place of Mr. G. B. Smith, who has resigned the post. He joined Guy's in October, 1891, qualified in 1896, and was House Surgeon to Mr. Howse in the following year. He took his F.R.C.S. last Autumn, and since then he has been doing Clinical Assistant at Moorfields Eye Hospital, where his work has won golden opinions.

From the Gazette's Special Pathologist.

T. B. L., Teddington.—The condition of this specimen is what has been described as cirrhus of the ovary. The stroma is exceedingly dense, the capsule is thickened and wrinkled, and the vessels have thick hyaline walls. The pyrexia was probably due to the condition of the lungs.

H., Ramsgate.—No tubercle bacilli could be found in the sputum.

G. E. H., Ramsgate.—This specimen is a fibrous epulis, the surface of which is ulcerated and covered with granulation tissue. It is not malignant.

J. M. C., Fishguard.—The growth on blood-serum after incubation consists of staphylococci and sarcinæ. The Klebs-Löffler bacillus was not found.

M., Reading.—In the absence of any instructions as to the nature of the material and the investigation required, we have examined the supposed sputum for tubercle bacilli, and found these present in large numbers.

PATHOLOGIST.

Coroner's Inquests.

As frequent enquiries are made at the Superintendent's office concerning the question of fees at coroner's inquests, the Superintendent has favoured us with the following extracts from the Act relating thereto. It is as follows:—

The following is an abstract of the sections of the Coroner's Act, 1887, relating to medical witnesses and to post-mortem examinations.

21. (1.) When the deceased has been attended by a legally qualified practitioner during his last illness or at his death, the coroner may summon such practitioner as a witness; if the deceased was not attended by a qualified man, the coroner may summon any legally qualified medical practitioner *who is at the time in actual practice in or near the place where the death happened*, and any such medical witness may be asked to give evidence as to how in his opinion the deceased came to his death.

(2.) The coroner may direct a medical witness to make a post-mortem examination, with or without an analysis of the contents of the stomach or intestine, provided that where a person states upon oath before the coroner that in his belief the death of the deceased was caused partly or entirely by the improper or negligent treatment of a medical practitioner or other person, such medical practitioner or other person shall not be allowed to perform or assist at the autopsy.

(3.) If a majority of the jury sitting at an inquest are of opinion that the cause of death has not been satisfactorily explained by the evidence of the medical practitioner or other witnesses brought before them, they may require the coroner in writing to summon as a witness some other legally qualified practitioner named by them, and further to direct a post-mortem examination of the deceased, with or without an analysis of the contents of the stomach or intestines, to be made by such last mentioned practitioner.

22. A legally qualified medical practitioner, who has attended at a coroner's inquest in obedience to a summons of the coroner under this Act, shall be entitled to receive such remuneration as follows; that is to say,

a. For attending to give evidence with no autopsy, one guinea.

b. For making an autopsy *with or without* an analysis of the contents of the stomach or intestines, and for giving evidence thereon, two guineas.

Provided that—

(1.) Any fee or remuneration shall not be paid to a medical practitioner for the performance of a post-mortem examination instituted without the previous direction of the coroner.

(2.) Where an inquest is held on the body of a person who has died in a county or other lunatic asylum, or in a public hospital, infirmary, or other medical institution, or in a building or place belonging thereto, or used for the reception of the patients thereof, whether the same be supported by endowments or by voluntary subscriptions, the medical officer whose duty it may have been to attend the deceased person as a medical officer of such institution as aforesaid, shall not be entitled to such fee or remuneration.

23. Where a medical practitioner fails to obey a summons of a coroner issued in pursuance of this Act, he shall, unless he shews a good and sufficient cause for not having obeyed the same, be liable on summary conviction on the prosecution of the coroner or of any two of the jury, to a fine not exceeding five pounds.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Surgical Wards.

Cases under Mr. Howse.

Naaman	3.	Lupus of foot.
	8.	Epithelioma of lip. Excised.
	11.	Old erasion of ankle. Stokes-Gritti's amputation for tuberculous recurrence.
	16.	Cystitis. ? Ascending pyelonephritis. ? Calculous pyelitis.
	17.	Infantile paralysis.
Dorcas	2.	Epithelioma of ear. Excised.
	5.	Compound fracture of humerus.
	12.	Fractured femur.
	14.	Furneaux-Jordan's amputation for hip disease.
	17.	Tuberculous axillary glands.
	18.	Bilateral tuberculous sinuses in breast.
Astley Cooper	12.	Backward dislocation at ankle-joint.
	32.	Compound fracture of tibia and fibula.

Cases under Mr. Davies-Colley.

Job	4.	Irreducible inguinal hernia. Radical cure.
	5.	Tuberculous knee. Excised.
	6.	Strangulated hernia. Kelotomy.
	7.	Caries of os calcis.
	8.	Double hip disease. Lardaceous kidneys.
	11.	Enlarged cervical glands. ? Malignant.
	12.	Lumbar abscess. Incised.
	20.	Furneaux-Jordan's amputation for hip disease.
	22.	Chronic streptococcal ulceration on fore-arm.
	23.	Mastoid abscess. Antrectomy.
	25.	Bilateral gangrene of toes.
Lydia	1.	Traumatic encephalocele.
	4.	Intracapsular fracture of neck of femur.
	5.	Fractured patella. Wired.
	6.	? Hydrocele of inguinal hernial sac. ? Omental hernia.
	8.	Strangulated femoral hernia. Kelotomy.
	9.	Epithelioma vulvæ. Excised.
	10.	Sinuses in breast. ? Tuberculosis. Scraped.
	12.	Carcinoma recti.
	13.	Fractured femur. Hodgen's splint.
	14.	Rectal ulceration with fistula.
	15.	Needle in colon. Laparotomy.
	16.	Tuberculous inferior radio-ulnar joint. Excised.
	17.	Moveable kidney.
Cots A & C.		Fractured femur. Vertical suspension.
Cornelius	3.	Outward dislocation of knee.
	5.	Fractured patella.
	6.	Fractured femur. Fractured radius and ulna, left. Compound fractured olecranon, right.
	14.	Fractured ribs.
	15.	Fractured patella.
	17.	Fractured base.

Cases under Mr. Lucas.

Lazarus	4.	Acute appendicular abscess. Appendicectomy, and abscess drained.
	5, 6, 7.	Spinal caries with abscess.
	8.	Tuberculous ankle. Excised.
	9.	Old ruptured urethra. Perineal sinus now being closed.
	19.	Backward dislocation of elbow-joint. Excised.
	20.	Large thrombosis of varicose veins.
Martha	3.	Recurrent cancer in supraclavicular glands. Thirty-five months since breast was amputated.
	5.	Tuberculous elbow. Excised.
	7.	Talipes equino-varus. Tenotomy of Tendo Achillis.
	8.	Fractured femur. Hodgen's splint.
	9.	Burns on face. Skin grafted.
	14.	Gonorrhœal synovitis of knee.
	17.	Æt. 4. Fractured femur. Hodgen's splint.
	21.	Flexed knee after erasion for tuberculous disease.

Cases under Mr. Golding-Bird.

Luke	9.	Epithelioma of fauces.
	16.	Old infantile paralysis.
	21.	Tuberculous elbow.
Charity	9.	Gummatous perichondritis of larynx.
	13.	Dislocation of inferior radio-ulnar joint. Operative reduction.
	16.	Fractured femur.

Cases under Mr. Jacobson.

Naaman	19.	Gonorrhœal synovitis of knee. Drained.
	20.	Suppurating hæmatoma on thigh.
Dorcas	20.	Mammary abscess. Incised.

Cases under Mr. Symonds.

Job	13.	Bronchocele. Right lobe excised.
	14.	Talipes carus. Plantar fascia divided and foot wrenched.
	16.	Nasal polypi, frontal sinus abscess. Drained.
	18.	Syphilitic stenosis of larynx. Tracheotomy.
Ruth	29.	Laryngeal stenosis. Post diphtheritic.

Cases under Mr. Lane.

Lazarus	11.	Ununited fracture of tibia: wired.
	13.	Fibroma cutis. Excised.
	14.	Sarcomatous axillary glands. Excised.
Martha	10.	Loss of tibia from necrosis. Rabbit's femur grafted in.
	11.	Carcinoma mammæ. Excised.
	12.	Suppurative arthritis of knee. Amputation through thigh.
	13.	Ankylosed hip.

Cases under Mr. Dunn.

Luke	1.	Periostitis of mandible and secondary glands.
Charity	21.	Cystic adenoma of breast. Excised.
	22.	Recurrent appendicitis.
	23.	Syphilitic ulceration of palate.

"Clinical."

1. Apical pneumonia.
2. HCl. poisoning.
4. Renal asthma.
5. Carbolic acid poisoning.
7. Appendicitis.
9. Pneumonia. Empyema.
11. Cirrhosis. Pneumonia. Pleuritic effusion. ? Pneumococcal arthritis.
15. Mitral stenosis and regurgitation. Aortic regurgitation. ? Stenosis.
17. ? Tubercular meningitis. ? Thrombosis of basilar artery.
28. Suppurating hydatid of liver. Operation.
29. Hydatid of liver. Operation.
33, 34. Tracheotomy.

Chapel News.

The fund for providing panels for the Reredos is making satisfactory progress. In addition to the donations already acknowledged in the Gazette the following have been received:—

	£	s.	d.
A Probationer	0	2	0
Nurse Roffey	3	3	0
Nurse F.	0	5	0
Miss B. Baker	0	2	6
Miss K. Taylor	0	2	6
Miss A. Park	0	2	6
Miss V. Wood	0	2	6
Miss A. March	0	2	6
Nurses (Out-Patient's Department)	0	10	6
Nurses (Queen Ward)	1	0	0
N. Davies-Colley, Esq., M.C.	1	1	0
Sister Patience	0	2	6
Henry Lafone, Esq.	5	0	0
Miss Swift	1	1	0
Miss M. C. Lindon	0	2	6
W. H. A. Jacobson, Esq., M.Ch.	1	0	0
Miss Spedding	0	3	0
Miss Garland	0	2	6
Miss Sycamore	0	2	6
Nurse Pearce	0	4	6
Nurse L. B. Douglas	0	2	6
Miss C. Madge	0	5	0
Miss F. A. Lew	0	7	6
Amount already acknowledged	70	3	7
Total	£85	11	1

The artist promises that the panels shall be finished by May 1st.

Nursing News.

On April 15th, Nurse Wiltshier left the hospital after more than five years' service. Probationer M. A. Brown has been appointed head nurse in Cornelius ward in her place.

On April 15th, Nurse Purkis left the hospital after completing her three years' training, to take up her work at the Private Nursing Institution. Nurse Haughton (Theatre nurse) has been transferred to Mary ward in her place, and Probationer M. Allen, has been appointed head nurse in the Theatre.

On April 12th, two additional head nurses were given to Bright ward, and two probationers were withdrawn. Probationers E. Newton and Potter have been appointed to these posts.

Papers by Guy's Men.

A Series of Three Cases of Typhoid Poisoning by Sewer Gas. Memorandum by F. Wyatt-Smith, M.D., B.C.—*British Medical Journal*, March 25th.

Correspondence.

To the Editor of Guy's Hospital Gazette.

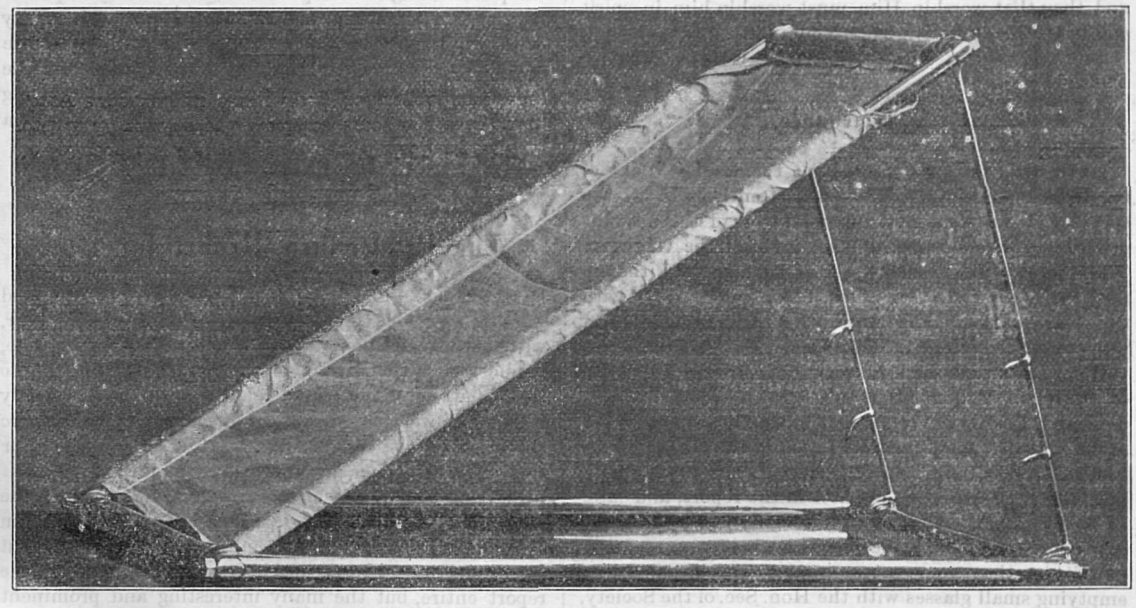
Trendelenburg's Position in Abdominal Surgery.

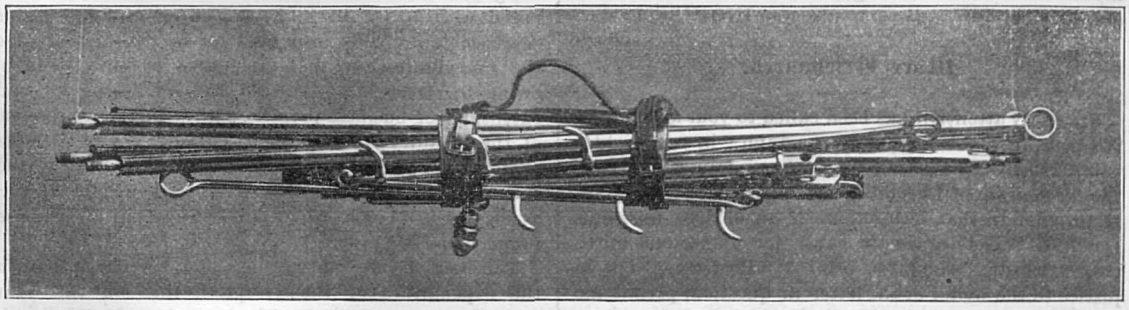
Dear Mr. Editor, — The method of elevating the pelvis in certain abdominal operations is very commonly seen in Continental operating theatres, but is somewhat rare in England.

If the advantages of this position were known, I think it would come into general use. One of the difficulties consists in its being only possible to produce Trendelenburg's position with a somewhat cumbersome and expensive table, such as that which can be found only in the theatre of a large hospital.

Those who like myself are in the habit of being called upon to operate in private houses of every description may find useful the apparatus that I wish to describe.

A glance at the photographs will show that it can be doubled up into a small space making it easily portable, its weight not exceeding seven pounds. The apparatus is constructed of light steel tubes, such as those used for making bicycles. These can be quickly fitted together and kept in position with small nuts. Any small table is suitable for it to be laid flat upon, and after the patient is placed on it the inner and smaller frame-work, carrying a stout holland webbing, can be raised to an angle of 40 degrees if needed or easily lowered to about 30 degrees. The weight of the patient being sufficient to keep the whole apparatus quite firm.





Messrs. Holmes, Bicycle Manufacturers, Norwich, are the makers of this one.—I am, Sir, yours faithfully,

THOMAS H. MORSE, F.R.C.S.

The Donations for the central panel of the reredos in Chapel.

Dear Sir,—To beg for and spend £90 in money for the above purpose seems to me an effectual way to hinder contributions towards the real needs of the hospital. Many will think with me that money spent for the above purpose is neither pleasing to God, since "the Most High dwelleth not in temples made with hands" (Acts vii., 48), nor helpful to man for worship, since "God is a spirit: and they that worship Him must worship him in spirit and in truth" (John iv., 24).—Yours faithfully,

AN OLD GUY'S MAN.

A Grievance.

Dear Sir,– As I was present at the Ladies' night of the Debating Society, and listened attentively to all the speeches, I was somewhat surprised to read the account given by your reporter in the last issue of the Gazette. While most of the speeches were fairly reported, though necessarily somewhat curtailed, I was much struck with the clearness, logic, and oratorical brilliancy of a short pithy speech by Mr. Shufflebotham.

But what struck me most was, that although I listened carefully to that gentleman's speech when actually delivered, I could not remember having heard any of the arguments or quotations that I read in the Gazette.

Mr. Shufflebotham's speech caused some amusement, but I see no mention of laughter in the report, and later in the evening it got somewhat roughly handled by the opposition, of which no mention is made by your reporter. Can it be that your representative was beguiled into emptying small glasses with the Hon. Sec. of the Society, or was he absent when the latter spoke, and put into his mouth the words which ought to have come from it?—I am, etc.

INQUISITIVE.

More Grievances.

Sir,—My attention has been called to your issue of the 9th inst., in which appears a paragraph "in your lighter vein," relative to a letter that appeared in the *British Dental Journal* of December last, signed L. Strangeways Hounsell. In that letter there is an obvious misprint. Doubtless it is a legitimate cause for uproarious mirth that "Register" should be printed "Registrar," but in justice to the writer of the letter in question, permit me to point out that the mistake was that of the printer (whom by-the-way we have changed—*post hoc si non propter hoc*) and for which this journal must bear the heavy responsibility. I need hardly say that Mr. Strangeways Hounsell's MS. contained no such absurdity. Personally I do not regret a printer's error that has been the cause of innocent merriment to so serious a journal as your own; it is only a matter of surprise to me that it took four months for your eagle eye to discover a slip that was laughed over and forgotten before the beginning of this year. I trust this side-splitting joke was not the cause of the decease of the "late lamented *Guyoscope*," in which journal I note the cutting "was to have been reproduced."—Yours very truly,

EDITOR, *British Dental Journal.*

I deeply regret that I should have caused pain to the Editor of *The British Dental Journal*, and I beg that he will accept a complete apology. Of course I had no idea that the letter referred to contained a misprint, but I am quite willing to accept the editor's kindly explanation. I can only hope that any loss of personal dignity he may have sustained will be fully compensated by the gratuitous advertisement given to his paper. Meanwhile I should like to thank him for the leniency in defending his honour with the broad sword; he might have used a Gatling gun.—Yours,

THE WRITER OF THE ARTICLE.

The Dispensary Report for 1898.

Patients come and patients go, and a lot of silent good work is expended upon them throughout a long year, without advertisement and without, as a general rule, public recognition, owing to the technical nature of the treatment. But the public rejoices in figures, especially if juggled with by means of diagrams and domestic similes after the manner of Mr. Holt Schooling. For this reason nothing gives such a vivid idea of the vast utility and benefit of such an institution like Guy's as the Dispensary Report. Here are figures in rows, figures in columns, everywhere figures, mostly very large ones, but all interesting. Space forbids the publication of the report entire, but the many interesting and prominent facts may be of interest to some. In 1898 there were altogether 70,856 attendances at Out-Patients, as compared with 73,742 in 1897—a decrease of 2,886. This decrease is probably accounted for by two factors—one the ever-diminishing habitable area of the Borough, owing to street improvements, railway extensions, and extensions of business premises; the other, the presence of the Enquiry Officer at Out-Patients. The patients paying 3d. a time for medicine, unless unable to pay and certified by the Enquiry Officer, brought in £874 9s. 9d., as against £921 10s. 3d. in 1897—naturally a decrease proportional to patients.

The cost of surgical dressings is a very large item in the expenditure of the Hospital, the bill this year amounting to £1,592 12s. 8d., as against £1,504 9s. 5d. in 1897. Bandages, so lightly regarded by the joyous dresser and ward clerk, cost £518 16s. Iodoform gauze cost £142 2s. 8d. this year, as against £98 11s. 5d. last year. The number of patients has not increased in a corresponding proportion, and the price of gauze has not increased, so there has been some increased use of iodoform gauze somewhere. The aseptic treatment of wounds is apparently slightly on the wane. Lint cost £311 11s. 5d.; absorbent wool, £101 1s. 8d.

Side by side with an increase in the cost of surgical dressings there is an increase in the cost of antiseptics. Iodoform cost £77 14s. 4d., over £7 more than last year. Lysol cost £101 8s. 1d., against £66 9s. 1d. in 1897. The cheapest antiseptic and the one that goes farthest, but also the one with the greatest limitations, is Hyd. Perchlor., the bill amounting to but a paltry £5 12s. 2d. A new item is £5 4s. 6d. for chinosol; formalin cost £3 5s. 2d. Anæsthetics cost about the same as last year—ether, £52 7s. 11d.; chloroform, £35 5s. 4d.; nitrous oxide gas, £35 0s. 6d.

In the drug department the absolute cost is not given, but the items are arranged under the head of increased and decreased cost. It is easy and instructive by this means to trace the fashion in drugs and note the prevalence of various diseases. Thus one sees that Sp. Armoraciæ Co. cost £6 2s. 6d. less this year than last, from which one might infer that the dread disease of "wind round the heart" was on the decrease. But on the other hand one finds that oil of cajuput, the present fashionable remedy cost £3 17s. 4d. more, and as this is only given one or two drops at a time, there must evidently be a large demand for the ease which it so quickly brings. So with regard to flatulence, things are where they were.

Extract of malt cost £72 18s. 1d. more this year than last, and there is a quietly sarcastic little note explaining this increase which is worth quoting in full. The report says:—"The great increase (£72 18s. 1d.) in extract of malt is mainly due to the assistant house-physicians, who now prescribe this extract for nearly every one of their out-patients. The cost of this article in 1894 was £9 5s. 7d., in 1898 £142 17s. 6d.—a difference of £133 11s. 11d." Whether it is ordered for everybody or not, it is a most valuable preparation, and once it has been ordered for patients they will come and clamour for it again and again, and worry till they get it, despite economy.

Other items of increased cost are gutta-percha tissue, an increase of £12 14s. 2d.; sal alembroth wool, £20 10s. 8d.; and salicylic wool, £31 4s. 8d.

Items of decreased cost are antistreptococcic serum, £24; grey gauze, £19 5s. 2d.; carbolic gauze, £12 6s. 6d.; phenazone, £18 12s., etc.

In the year 1898, 26,084 syphons of soda water and lemonade were filled at a cost for gas of £6 12s. 9d. This makes the average man's mouth water when he knows that he has to pay 6d. a syphon at the retail shop, and then return the syphon. There ought to be money in the trade.

Mr. Collier winds up a most thorough and excellent report with the following astounding figures:—

	1898.
Various pills	588,300
Various ointments	5,671 lbs.
Various tinctures	362 galls.
Various syrups	600 galls.
Strapping plaster	103,000 yds.
Belladonna plaster	502 yds.
Blistering plaster	32 yds.

Taking the average diameter of a pill as a quarter of an inch, if all these pills were put side by side they would reach from statue of Thomas Guy to ——; but no, we said we wouldn't!

Inquests.

Why is it that to the average man there is something awe-inspiring and serious about the holding of an inquest? The experienced man may reply, "Because he has never been to one." That is not a sufficient answer, though, and indeed I have never found, although I have diligently sought, any satisfactory explanation of why it is that the British inquest, though ridiculed in all times and by all kinds of writers, from Shakespeare downwards, still excites the respect and even the admiration of us all. Perhaps it is that it is always primarily concerned with a corpse, and that the presence of death quiets the most ribald laughter, or perhaps it is that any man, with a few exceptions, may be called on to help in the interesting ceremony of sitting on a late lamented, and so refrains from laughing at that which some day he may form a part of. By a merciful dispensation we of the underpaid profession are exempt from ever thus rendering ourselves ridiculous, and thus we can throw stones without putting the shutters up in front of our own windows.

I remembered well my first inquest. How I entered with a rapidly acting heart and skin, and in spite of a dauntless bearing and a look of conscious rectitude which I adopted, prayed devoutly that the newspaper reporter would be taken with colic and that his distorted version of the proceedings might never reach the eyes of my aged parents, who would infallibly think I was professionally damned if they saw me figuring in "another hospital scandal." The deceased in question had imbibed somewhat freely, and had then pitted his unaided strength against that of a two-horse van in motion. As an immediate consequence he appeared in a bellicose, muddy, and bleeding condition in the front surgery, was admitted into Cornelius, there developed appendicitis, for which he was transferred to a medical ward and eventually died some months later under my careful supervision, of pneumonia, having completely recovered of the scalp wound which brought him into the hospital.

My case was one of a series of three being held that day, and, as I was new at the work I turned up at the appointed time, and being, of course, too early, amused myself watching the arrival of the jurors and other officials. The jurors, with one exception, were of the collarless intelligent unwashed type which one sees to perfection in Tabard Street and Bankside. The one exception was a small nervous-looking man, with a fluffy beard and a frightened expression. He kept his coat carefully buttoned all the time, whether because he had forgotten to put on a waistcoat, or whether he thought that some of the "good men and true" around him would steal his watch, I don't know. Then when I

though they really were going to start it was discovered that they were one short and the clerk disappeared into the Borough to exercise the power of the law on the first man he found, and shortly appeared with his victim. He was of the same type as the rest of the jury, but he had one advantage over them—he was drunk. One glance at his face was enough. What was the worst part of it all was that he was in the pugnacious stage of alcoholism. However, as any suggestion of such a thing would have entailed a noisy, and possibly painful discussion, he was promptly sworn, and once sworn could not be unsworn till after the inquest. The jury then disappeared to view the bodies, and then only did I feel elated. I knew that would upset them, and when I saw them returning with whitened faces and expressions of disgust, I felt that after all a medical training gave a man some advantages. Then we really did get to business, and started proceedings by calling deceased's mother as a witness. The swearing in of this good lady was not a simple matter, as she would curtsey to the coroner and say, "yes, sir," instead of listening to the clerk; and she started the first series of kisses on the book directly the clerk commenced administering the oath, and she also held the book in the wrong hand, all of which details stamped her as a novice.

Her evidence was also somewhat difficult of extraction as she was deaf and spoke low, and, of course, the coroner being deaf as well, what with her not hearing his questions and his not hearing her answers, matters were getting a little complicated. However, it appeared that she had not seen deceased for five years, so she was ushered out and the policeman was called. Here the alcoholic gentleman demanded in loud fierce tones what was the cause of death. He was pacified and told it would transpire later and subsided with the expression of a man who is convinced that he is the victim of a conspiracy.

Various other witnesses then appeared and swore diversely as to whether the deceased was drunk at the time, or whether the man who drove the van was, but there was nothing exciting about their evidence, except that the alcoholic inquired about every five minutes in tones growing louder and more irate as to what the cause of death was. Then came my turn, and being sworn I gave my name in loud clear tones, and the coroner got it down correctly at the third attempt.

"You are a house-surgeon at the hospital?" he asked.

"No; house-physician."

Now that is just one of those questions that always annoys me—why does everyone suppose that if you are a resident at a hospital you must either be on the staff or a house-surgeon? It is a fact that they do. When I first got the appointment I tried to explain to my friends and relatives what an important person I really was, and how insignificant a house-surgeon was compared with a house-physician. But it used to let me in for a definition of a medical case as distinct from a surgical, and that was hopeless, and I always left them with the impression that I was a cross between a bathman and a dispenser, and nobody of much importance after all.

However, to return. I got through my evidence satisfactorily and gave the alcoholic gentleman the much desired cause of death, and in return he censured me and the hospital authorities generally because I had not dressed the scalp wound, but finding no one to back him up he subsided sullenly and went to sleep. One of the jury then began to question me as to my knowledge of two-horse vans, but was cut short by the coroner, and eventually, after some discussion, a verdict of death from natural causes was given. This woke up the devotee of Bacchus, who insisted that the coroner had written the verdict down wrong. He pointed out that the verdict given was "that deceased had died a natural death." Of course he was well aware, he said, that the meaning of the words was essentially the same, but he contended that as the verdict was given, so it ought to be recorded. I need hardly say he gave this opinion in the native tongue, and in thickish utterance, but as argument was out of the question, he gained his points, and settled down once more with an air of a man who was determined to see justice done at all costs.

Now what is so inexplicable to me is why they did not call me first and save a long and tedious cross examination of witnesses about matters which after all had nothing to do with the death of the man? The newspaper report was not very terrible. I was represented as saying that it was an extraordinary case and I was unable to account for it, and a pal sent me the cutting, and condoled with me for having had my ignorance exposed in public. C.

Sport.

Rugby Football.

REVIEW OF THE SEASON 1898–99.

The season may fairly be considered to have proved as great, if not a greater success than the previous one. The trial games in October were much keener than usual, and this keenness resulted in the formation of a fourth fifteen—we believe the first time a fourth team has turned out for the Hospital—which played really well on several occasions.

In all the first fifteen played 25 matches, and of these won 14, lost 8, and 3 games were drawn: 162 points were scored, against our opponents' 122. Combined with St. Thomas's, we as usual beat Penarth, and were beaten by Cardiff. This season we, however, beat Blackheath. In the Cup Ties Middlesex scratched to us in the first round, and in the second and third rounds we defeated St. Thomas's easily, and St. Mary's after a hard game. London proved strong opponents in the final, but were beaten by three tries to nothing. The three tries were scored by F. L. Rae—a truly great performance. We scored 40 points to nil in the four rounds.

We cannot help thinking that if the cup ties were played earlier in the season our fifteen would do better; they certainly appeared "stale" in the last matches.

During the season F. L. Rae scored 14 tries for us, next to him, F. W. Sime scored 11 times; F. D. S. Jackson, T. P. Thomas and H. A. Cutler twice each, and C. T. Hilton, M. C. Wetherell, C. W. Smyth, F. J. Pierce, G. Shorland, J. H. Wilkes, F. E. Walker, H. V Bagshawe and C. D. Pye-Smith got over once apiece. A. O'Brien placed most of the goals.

Two new Rugby "Blues" have been elected,—A. O'Brien and K. V. Trubshaw.

The Second fifteen again entered for the Surrey Cup, and were unfortunate in being beaten by Surbiton in the semi-final round. They displayed capital form all through the season. The third and fourth teams also played matches regularly, and the result of the season proved fairly satisfactory.

Our capability to turn out four teams every Saturday, cannot be but a good indication of the future of Guy's Rugby Football.

SUMMARY OF FOURTH XV. MATCHES.

Matches played	12
„ won	6
„ lost	6
Points for	125
„ against	89
Point majority	36

Association Football.

REVIEW OF THE SEASON.—FIRST ELEVEN.

The Association season came to an end on March 18th, and although the results are hardly up to standard, everything being considered the season has not been an unsuccessful one. We have only played 18 matches, of which 8 have been won, 7 lost, and the remaining 3 drawn. The goal average, too, is only just on the right side, being 46 for and 43 against. The reason that so few matches were played is that no less than seven matches were scratched after Christmas, partly by our opponents and partly owing to our ground being unfit because of the heavy rains.

In the Inter-Hospital Cup, after beating Charing-Cross by 3–1 in the second round, Bart's beat us in the semi-final by 4–2. In this match we were without Wiltshire, who was unable to play after the accident he received when playing in the Amateur Cup, and although he was greatly missed Hughes, considering his untrained condition, filled the vacant place with great credit.

In the Surrey Cup we beat Chertsey in the first round by 7–0, but in the second round we were drawn against Ewell, one of the best Surrey teams, and who up to the time of playing us had not been beaten, so, although beaten by 3–1, we were not disgraced.

The fixture list was an exceptional one, several good clubs appearing in it for the first time; unfortunately, how ver, it was in a great measure spoilt owing to the large number of matches scratched. Our best performances were perhaps the games with Ipswich, and the first of the matches against both Weybridge, and Reigate Priory. The match against the Old Brightonians, although ending in a draw, proved to be a very good game. Against both Hastings and Eastbourne we lost; in the former the margin was a wide one, but nevertheless the game was much more even than the score would lead one to suppose.

Turning now to the team, up to the first Reigate match we were able to play practically the same team regularly, five of last year's men turning out. In this match Gray injured his knee and was unable to play again, and from this time Mandy only played occasionally; thus, only three of last year's team played all through the season.

McAlpine turned out once, but did not do so again owing to his old accident.

After Christmas we had great difficulty in getting a regular line of forwards. Manser, who played for us then, considerably strengthened it, but his services were lost for some time owing to illness.

Taking the forwards as a whole they have shown very in and out form, at times playing brilliantly, at others without any method. Wiltshire was undoubtedly the best of the lot, and notwithstanding his unfortunate accident scored most goals, which proves his usefulness. Norton, too, did a lot of good work, and is second on the goal list.

Of our back division, the halves have been most conconsistent; Hall did not play quite so well at the end of the season, but this can well be attributed to the arduous appointment he was holding at that time. Robson was most efficient at back, having much improved since the previous year. Smith, although unsafe at times, was in much better form at the end of the season.

P. S. Mandy will be out of his year next season. Honour Caps have been awarded to W. M. Robson and H. P. Wiltshire.

SECOND ELEVEN.

The past season must be considered a very satisfactory one to the second team, as many good matches were won, concluding with a win in the final of the Inter-Hospital Junior Cup.

For the first few matches the constitution of the team was much altered, and consequently the form shown was very poor. When, however, the team was made up there was a great improvement, and the first good win was scored against the Central Technical College, our combination being perhaps the best of the season on that day. In the second round of the Surrey Junior Cup, Balham School were encountered, and after playing two drawn games, we were defeated by 4 goals to 2, playing ten men the whole time, of whom one was practically disabled a few minutes from the start.

After Christmas, owing to accidents in both first and second teams, the second team was occasionly poorly represented, or the record for the season might have

been considerably improved, losing to Eversleigh and Richmond Reserves with weak teams.

In the Inter-Hospital Junior Cup we met St. Mary's in the first round, and though handicapped by the absence of Camps and Langdale in the forward line won by 3 goals to 2. In the final round against St. Bart's., Lacey and Roberts were prevented from playing, the former by illness, and the latter by an injury received when playing against St. Mary's. Hilton and Rust filled the vacant places well, and after a very exciting game, Guy's were returned the winners by 3 goals to 2.

The team shows an all-round improvement on last year's, particularly forward. Roberts has played at centre, Camps and Lacey on right, with Peall and Morris, the latter being replaced by Langdale in the latter half of the season, constituting the wings.

The half-back line is the most regular part of the team, being filled by Cole, Greenfield and Smith. It has been difficult to find backs all the season, but Matthews has played when not playing in the first team, and has been an extremely good back. The other position has been filled by many men—Bent eventually playing there. Gardiner kept goal in the first few matches, but was replaced by Carter, who played consistently and well. Not being eligible to play in the Cup Ties, his place was filled very ably by Heap. Rust played in most matches in different positions.

The record for the season is:—Matches won 11, drawn 4, lost 6. Goals for, 56; against, 29.

Guy's Hospital Lawn Tennis Club.

It is to be hoped by the time this is in the hands of the printer, that the weather may have allowed Harris to put a few courts at Honor Oak in playable condition, and so give men a chance of getting fit for the trial game on Saturday, May 7th.

For the benefit of tennis playing Freshmen—and we trust they are both numerous and keen—we think that a few remarks thus early about the Club and its aims, may be found useful.

First the "Blue Book" of the Club's Union should be read, and the Club's match card purchased. We have at Honor Oak Park eleven courts, and room for more should they be found necessary. Of the eleven courts three are reserved for matches and occasional team practice. It is hardly necessary to say that the courts, being a part of Guy's, compare favourably with any round London.

The foremost aim of the Tennis Club is to secure for the season 1899 the Inter-Hospital Tennis Cup now held by London, a Cup which has been absent from our smoking room since 1892.

Of the members who more or less successfully represented the Hospital last season, Messrs. Lacey, Wacher, Cross, Ransford and Mandy remain to form a working nucleus. Kelsey, who combined with Wacher was playing a strong game at the end of last season, will be badly missed.

The first match will be played on the Saturday following the trial game, and as the six to represent the Hospital must necessarily be chosen early, it behoves Freshmen not to delay in coming forward.

To create keenness amongst men there is the Lane-Washbourn Singles Challenge Cup open for competition to men in their year. Then there is the Singles Handicap, and we hope this season to successfully run a Doubles Handicap.

When we see in the match card for the coming season such names as Wanstead, Connaught, Chiswick Park, The Kent L.T.C., etc., etc., it will only be by constant practice and general keenness that anything like a balance of wins in the Hospital's favour can be shown at the season's end.

That the game is popular at the Hospital though it may be in more or less an elementary stage, is evident, seeing that over 200 men used the Courts last summer. To foster talent an attempt is going to be made this season to run a second team—financial difficulties alone standing in the way.

To conclude, all important tennis items are duly posted in the colonnade and smoking room, and the Secretary and Committee men are only too happy to advise men on tennis matters connected with the Hospital.

Appointments.

NAVAL AND MILITARY.

Inspector-Gen. Thomas H. Knott will succeed Inspector-Gen. H. Macdonnell, C.B., on the retirement of the latter officer in June next.

Surgeon J. G. Watt is appointed to the *Triton*, and Surgeon F. D. Lumley to Haulbowline Hospital.

Captain W. G. Beyts is seconded for service on the Staff as Surgeon to the Commander-in-Chief in India, Sir William Lockhart.

The following changes of station have been officially notified:—

Sur.g-Gen. H. S. Muir, M.D.,	from	Egypt	to War Office.
Lieut,-Col, H. J. W. Barrow	"	Egypt	" Punjab.
Capt. E. M. Pilcher	"	Punjab	" England.
Lieut. H. P. W. Barrow	"	Netley	" Aldershot.
Lieut. H. D. Packer	"	Netley	" Aldershot.
Lieut. L. Humphry	"	Netley	" Gosport.

Births.

DUPIGNY.—On April 19th, 1899, the wife of J. Elford Dupigny, M.R.C.S., L.R.C.P., L.D.S. Eng., Claremont Lodge, 7, Streatham Hill, S.W., of a son.

HODGSON.—On April 11th, at Blisworth, Northamptonshire, the wife of Harold Hodson, M.B., B.S. Lond., of a son.

HOWSE.—On April 7th, at 59, Brook Street, Grosvenor Square, W., the wife of H. G. Howse, M.S., of a son.

SKINNER.—On April 7th, at Bank House, Rye, the wife of Ernest W. Skinner, M.D., of a daughter.

Death.

BARNES.—On April 5th, at Perth, West Australia, John Shepperson Barnes, B.A., M.D., eldest son of John M. Barnes, of Morningthorpe, Norfolk, aged 31. By cable.

Ed.—H. L. E.

Contents.

	PAGE
Rest and Digitalis in Heart Disease: Clinical Lecture by Dr. Taylor	181–188
Hospital News	188
Chapel News	189
Pupils' Physical Society	189
Pass List	189
Nursing on the Niger	190
Notice	190
From the Gazette's Special Pathologist	190
Papers by Guy's Men	190
Passim	191–192
Burns and Scalds: Paper by Mr. F. E. Walker (*Concluded*)	192–198
Correspondence: The Reredos in the Chapel.—A Reply	198
Nursing News	199
In Lighter Vein	199–200
Appointments	200

Calendar of Coming Events.

May, 1899.

Sat. 6.—Messrs. Howse and Jacobson's take-in; Drs. J. A. Glover and J. M. Brydone; Cl., G. N. Meachen.
G.H.C.C., I., Waldegrave Park, 11 a.m., home.
II., St. Mark's Coll., 2.30 p.m., away.
G.H.L.T.C., Trial Match, home.
Hos.-Scho. C.C., Hanover, home.

Mon. 8.—Practical Exams. for Dental Prizes begin. Extractions at 9 a.m.

Wed. 10.—9 a.m., Dr. Washbourn lectures on Bacteriology.
1.30 p.m., Clinical lecture by Dr. Perry.
G.H.C.C., I., Hornsey, 11 a.m., home.
II., City of London School, 2.30 p.m., away.

Thur. 11.—Messrs. Davies-Colley and Symond's take-in; Drs., W. Johnson and E. P. Mitchell; Cl., D. J. Munro.
Primary Fellowship Exam.
G.H.M.P.U., Address by H. W. Oldham, Esq Subject, "Bible Circles."

Fri. 12.—Exam. for L.D.S. Eng.
1.30 p.m., Clinical lecture by Mr. Jacobson.

Sat. 13.—G.H.C.C., I., Crystal Palace, 11 a.m., away.
II., Croydon, II., 2.30 p.m., home.
G.H.L.T.C., Boundaries, home.
Hos.-Scho. C.C., Plaistow, away.

Wed. 17.—G.H.C.C., I., Croydon, 11 a.m., away.
II., Marden, 2 p.m., away.
1.30 p.m., Clinical lecture by Dr. Shaw.

Thur. 18.—Messrs. Lucas and Lane's take-in; Drs., H. B. Foster and J. Atkins; Cl., F. D. Turner.
G.H.M.P.U., Address by Dr. Grattan Guinness.

Fri. 19.—1.30 p.m., Clinical lecture by Mr. Jacobson.

Sat. 20.—Cambridge 1st and 2nd M.B. Exams. Schedules to be brought to the Medical Office for signature.
G.H.C.C., I., Surbiton, 11.30 p.m., away.
II., Thornton Heath, 2.30 p.m., home.
G.H.L.T.C., Blackheath, away.
Hos.-Scho. C.C., Courage & Co., home.

Guy's Hospital Gazette,

MAY 6, 1899.

Rest and Digitalis in Heart Disease.

CLINICAL LECTURE BY DR. TAYLOR.
February 25th, 1899.

Gentlemen,—The case I am going to speak about to-day is of a kind that is not at all uncommon in our wards; it is a case of Mitral Disease. A young woman, twenty-one years of age, was admitted on the 11th of February into the Clinical ward, and came under my care when I took over the ward on February 15th. She had been previously admitted into this ward on December 24th of last year, with practically the same symptoms as on the present occasion. She had chorea when she was ten years of age, and there was no history of rheumatism. Dyspnœa had been increasing gradually for the last three or four years. Her present illness began with cardiac distress and coughing, with feelings of faintness and sickness, and with headache.

On admission, in December, she had a running, irregular heart-beat, only about half the beats reaching the wrist. She was very collapsed and some bronchitis was present. The impulse of the heart was in the fifth space half an inch from the nipple; dulness did not extend beyond the right edge of the sternum. There was a rough diastolic bruit at the apex traceable into the axilla, and there was a short systolic murmur at the apex. The sounds were normal in the pulmonary and tricuspid areas. Mitral regurgitation with bronchitis was diagnosed. The patient was treated by a mixture containing ten minims of the Tincture of Digitalis, five minims of Tincture of Nux Vomica, and five minims of Tincture of Belladonna, every four hours.

The following day she was a little better, but towards the evening got worse, and an injection of ether was given. On the 30th December she was much better. On the 1st January, eight days after admission, occasional râles

were heard in front of the chest; these were rather more frequent behind, and more audible on the right side. On January 4th, her heart was still irregular in rhythm, and the same bruits were audible. On this date the amount of Tincture of Digitalis was reduced to three minims. On the 18th of January, the report states, "The patient's heart is more regular to-day and her pulse a little harder." On the 16th she had some Tincture of Strophanthus added to her mixture, and by that time she had been up, after dinner, for three days. On the 21st January she was discharged. The bruits were then about the same as on admission, the patient complained of pain over the heart much less frequently, the heart was more regular, and the pulse better. Charts, appended to the report, show that between the 13th and 16th the pulse was from 63 to 60, and between the 16th and 20th, it was from 68 to 74. On admission the pulse was stated to be 74, so that the irregularity rather than the frequency of the pulse was the feature which had to be dealt with on that occasion.

She went to a convalescent home after her discharge, and returned to town on the 9th February. She had not been so well the last few days of her stay at the convalescent institution, and during the two days at home she had got worse. When she came to the hospital on the 11th February she was very distressed. Her heart was beating forcibly and irregularly, and at the rate of 130 in the minute. The impulse was in the fifth space in the nipple-line. At the apex were heard a systolic murmur and a short localised mid-diastolic murmur. The systolic murmur was traceable to the ensiform cartilage, so that probably there was tricuspid regurgitation; and in addition, at the left edge of the sternum, and most distinctly in the third intercostal space, was a diastolic murmur, of which it was difficult to say with certainty whether it was pulmonary or aortic. The second sound was accentuated. There was much cardiac pain and tenderness. The abdomen was normal. The liver and spleen were not enlarged. The legs were very slightly œdematous; tongue clean; bowels constipated; urine normal. The patient was given a mixture containing Tincture of Strophanthus ten minims, Ammonium Bromide ten grains, Spirits of Chloroform ten minims, Ticture of Cardamoms one drachm, and Peppermint Water half an ounce; and the bowels were acted on by Colocynth and Calomel. The following day the heart was somewhat quieter, and the patient felt better though still somewhat distressed. On the 13th the pulse was much slower. She was ordered four grains of Ferrous Carbonate. On the 16th the patient was still improving, the bruits were unchanged, and she was allowed to get up after tea. On the 17th the pulse was much slower, and the patient was not distressed after being up.

On the 18th the mixture containing Strophanthus was omitted. Two days later she was keeping well, though the heart was still irregular and all the cardiac beats were not perceptible at the wrist. But on the 23rd she was worse again, the heart beats were more rapid, forcible and irregular, and she had more cardiac distress. She was ordered to bed again, and the same mixture as before, with ten minims of Tincture of Digitalis, instead of ten minims of Strophanthus, was given every six hours. The following day (yesterday) this was given every four hours, and rest in the recumbent position is now ordered to be maintained for at least two weeks, even though she should seem to be much better or well before that time.

Now, gentlemen, though it may not strike you at first as a remarkable case, there are many points of interest in connection with it, and lessons of importance which may be drawn from it. I shall say little of the diagnosis or of the nature of the case, not much more than to point out that this case illustrates what we so often see, that the physical signs which constitute the evidence of mitral stenosis are often latent or unperceived, and that the case is considered for a time, in consequence of a mitral systolic murmur, to be one of mitral regurgitation alone.

When the patient first came in, the main feature of the case seemed to be the mitral systolic murmur. It is true there was some question about a diastolic murmur, but it does not seem to have been sufficiently prominent to carry conviction to all minds. There is no doubt now that she has a pronounced diastolic murmur and a diastolic thrill. In this connection it should be noted that when the heart of a patient is going very fast and irregularly, the diastolic murmur and the diastolic thrill may be very difficult to appreciate. When the heart gets slower again, then the thrill and murmur become perfectly plain.

We might also usefully discuss the nature of the systolic murmur heard at the lower sternum, and the origin of the diastolic murmur which is heard at the left edge of the sternum. The former, though continuous with the

systolic bruit at the apex, is probably determined by tricuspid regurgitation, and the latter is quite possibly a pulmonary regurgitant murmur, dependent on the high pressure in the pulmonary artery which results from the co-existing obstruction and regurgitation at the mitral orifice. But to-day I wish to direct your attention to questions of treatment.

One of the great requirements with regard to the treatment of heart disease is that the patient should have *rest*. Now, here I may point out that our treatment in hospital is often somewhat different, for certain reasons, from the kind of treatment that has to be undertaken in private practice. One feature of this difference is that nearly all the patients who come into the hospital are, as a matter of routine, put into bed and kept there. You do not generally at the outset raise the question whether a patient has to be up or in bed. When he comes in he is put to bed, as a matter of course, and the treatment starts from that as a basis. On the other hand, in private practice that does not so constantly happen. The patient who consults you in private may ask you the question whether he has to go to bed or not; if he assumes anything at all, he will assume that he has not to go to bed, but to keep up and get about and do his business. So that your treatment is on a different basis in private practice from what it has been in hospital practice. Whereas in the hospital the patients are in bed as well as taking medicine, private patients will often expect to be treated without such an inconvenience as being confined to bed all the day, and that perhaps for a week, or two, or three weeks. A patient, for instance, who is suffering from cardiac symptoms may expect to be relieved by one or two bottles of medicine, even while he is daily going to business. He may call, perhaps, at the doctor's as he goes along, and he may feel it is a great hardship to be deprived of the pecuniary advantage of continuing his business, even though he is ill.

Now, in relation to heart disease, rest is, as I have stated, an important factor of the treatment, and it is desirable that you should, as it were, insist upon the treatment in that respect being carried out in the most rational manner; or if there is a difficulty in convincing your patient that bed is the best place for him, you should put upon him the responsibility of any delay that may take place in his improvement, and not too willingly yield to his desire to have a free hand in the matter.

It ought not to be difficult to convince a medical man, or a medical student, who has learned anything in physiology, of the desirability, in most cases of cardiac disease, of complete rest. The heart has to maintain the circulation of blood to all parts of the body. Every one of us knows, of course, the difference in the rapidity of the pulse in the erect and recumbent postures. Everyone knows that a quickening of the pulse follows from any kind of exercise, especially violent exercise. The first essential for existence is that the brain and various organs which are the life of the individual should be properly nourished. It is not in the same way essential to life that the locomotor organs should be properly nourished, though that is desirable. But if the heart is to be able to work in order to secure its own nourishment, and give it a chance of recovering from the weakness it has undergone, then it is clear that, though the locomotor portion of the human economy may to some extent be overlooked, yet the organic portion must be properly considered and cared for. Therefore it is quite certain that in a great number of cases of heart disease, in the great majority of valvular disease of the heart with which we have to deal, rest is most desirable and essential.

Then with regard to our private cases, the question is often asked, "If you say I am to have rest, what kind of rest do you mean? What do you mean by rest? May I get up in the afternoon? Is it sufficient if I get up after breakfast and lie on the sofa all day?" You there realise that the patient has a very imperfect idea of rest. The only absolute rest the patient can get is by being in bed. And, of course, the chief reason why he should be in bed is that if the patient gets up he has to go through the process of dressing, and changing his room, and going up and down stairs; and all these proceedings may upset, in the course of half an hour, what has been done towards his recovery during twenty-four hours or more. Furthermore, if the patient is in bed he realises that he must have somebody to attend on him more or less, and that he cannot conveniently get up, for instance, to poke the fire, shut the door, ring the bell, get a book off the side table, and go through little performances which in themselves are prejudicial, because they interfere with the complete rest which it is desirable to attain. Therefore, if your patient is ill with some form of heart disease requiring rest, you have a right to insist upon a measure of this kind.

In relation to heart disease there is another point which is more or less illustrated by our

present case. That is, if your patient has improved, do not be in too great a hurry to get him up; do not let him get up too soon. Just remember that the improvement you have brought about may be an improvement effected in a fortnight or three weeks after symptoms prolonged for three or four months, and that if you are to get the patient back to what he considers a normal position, you must leave him with a reserve of cardiac power and nervous power, by which he may manage to go on for a long time after you have dealt with him; otherwise, he may very soon get again into a similar condition to that in which you found him at first.

As I have said, the case which we are specially considering illustrates the danger which I have just pointed out. Here is a patient who is three weeks, apparently, in bed, and then she begins to get up, and in less than a week after this she goes out. She goes, it is true, to a convalescent home, but convalescent homes are not the places where patients can lie in bed all day.

However, only three weeks elapse and she is again admitted for somewhat urgent symptoms. Five days rest, with the use of Strophanthus, relieve her, and again she tries to approximate to normal conditions by getting up and omitting the medicine, and with this result, that in another week she is ordered to bed again.

I hope, if we can spare the space and room in the hospital, that we shall give her a sufficient length of time in the bed she occupies now in order to restore her much more effectually than before to health.*

I now come to the medicinal treatment of heart disease. This may be considered to be of two kinds. There is, first, the relief which you can afford to the heart by unloading the venous side of the circulation, and so diminishing, if possible, the strain put on the right ventricle and auricle of the heart when the blood comes to it sluggishly, and is, as it were, unwilling to move on. That may be done by various means which are called depletory, or excretory—*depletory* is the more comprehensive word. The drugs one commonly employs for this purpose are purgatives and diuretics. In our present case the patient was given some Colocynth and Calomel, and, no doubt, her bowels were effectively opened by them. In other cases worse than this, perhaps, that treatment may be repeated from time to time, in order to ensure that not only are the bowels emptied, but that a certain amount of fluid secretion shall be produced in the surface of the intestine, and so a certain amount of liquid get away from the venous system.

In the same way diuretics may be employed. It is quite common to give such diuretics as Nitrate of Potassium, Acetate of Ammonium, Tincture of Squills, and others for cardiac disease of this kind.

We have another method, viz., venæsection, which is also an important means of depleting the congested circulatory system. In certain cases of heart disease in which the condition is very severe, when the right ventricle and auricle are engorged, and are threatening to become powerless in consequence of the considerable distension that they undergo on the venous side of the circulation, the patient may be almost *in extremis*, and the removal of twelve or fifteen ounces of blood from the basilic vein, or jugular vein, has been found of great value. I do not wish to enlarge upon that part of the subject, but I would pass on to another interesting consideration, that is, the treatment of heart disease by so-called cardiac tonics or stimulants which act directly upon physiological working of the heart, and are not merely a means of withdrawing from the circulation the material the heart has to work upon. Of these, Digitalis is recognised to be the most valuable that we have. Strophanthus is certainly the next most useful. Then come some others, such as Convallaria, Citrate of Caffein, and Squills, but it is admitted by nearly all writers that Digitalis is the most trustworthy; that is to say, in the greater number of cases of cardiac valvular disease, and mitral disease especially, in which drugs are used, Digitalis will give more satisfactory results on the whole than the other drugs mentioned.

Now, what is the action of Digitalis? I am speaking clinically more than physiologically. Under what circumstances, in the wards, do we find that Digitalis is valuable, and when it is valuable what does it do, and how does it act? Now this is universally recognised: that it is in those cases in which the beating of the heart is rapid, irregular, and feeble that Digitalis does most good. It is important to bear in mind that, if a patient comes to you and you find there is a murmur at the apex of the heart, and you recognise the patient has valvular disease, that of itself is not a reason for giving Digitalis. If it is mitral disease, whether regurgitation or

* She remained thus in bed until March 18th (twenty-three days), when she was allowed up after tea, and she continued the medicine with the same frequency until March 27th, when it was reduced to six times a day. She went out feeling very well on March 29th, with orders to continue the medicine for a fortnight longer.

constriction, that also is not a sufficient reason for giving it. The reason for giving Digitalis is the condition of the heart's beat, and the way in which the heart beats, whatever the murmur may be. I do not mean to say that is the sole consideration, but, at any rate, the way in which the heart beats is the primary consideration.

Taking the case we have before us, a class of case in which you believe there is mitral constriction or mitral regurgitation, and in which you find that, in consequence of that, the heart is suffering from what is called want of compensation, and is beating rapidly and irregularly, then under these circumstances we find that in a great number of such cases Digitalis is effective. It checks the rapid action of the heart, strengthens the heart, and makes its beat more regular and normal. There are cases also where the pulse is rapid and feeble, without being irregular, and in these Digitalis will sometimes do a great deal of good.

The question then comes as to the dose of Digitalis, and it is a question in which every one of you must be considerably interested. Here, as in other diseases, of course the drug must be proportionate to the severity of the case. You do not want to give the maximum dose when the disease differs very little from the normal condition. But, on the other hand, if the condition be a severe one, you must be prepared to put on your dose to an adequate amount. I have received the impression that there is perhaps a somewhat excessive degree of timidity in the use of Digitalis in reference to cases of this kind. And that is one reason why I have chosen this subject for the present occasion. It seems to me that not infrequently the dose of Digitalis given has not been so large as it might have been, and that if it had been larger, a quicker and more rapid result would have been obtained.

Well, now, I approach this subject with some little diffidence, because I do not want to instigate anyone to give over-doses to his patients so as to do them harm when the intention is to do them good.

Teachers in general have very properly warned students that whatever they do they must not poison their patients, and the practitioner is therefore careful to give what he knows to be a small dose. But it is our duty not only to avoid doing harm, but also very positively when we can, to do good.

It seems to me possible that some of the excessive caution with regard to Digitalis may arise from the theory that it has a cumulative action. I must confess I thought a little while ago that the theory of cumulative action was no longer operating practically, but I am not quite clear that it is not. The theory of the cumulative action of Digitalis used to be put in this form—That Digitalis was a drug which was likely, if taken for a long period, to act prejudicially at some time or other, without any warning, and cause sudden death; that it might apparently be perfectly harmless during a period of weeks, and that then there might be a sudden development of symptoms which were fatal, the special symptom being failure of the heart.

Now, that Digitalis has a cumulative action, or an action which deserves to be specified by some such name, must be allowed. Every drug has a cumulative action under certain circumstances. If you take anything into the body, whether it is drug or food, you must ensure that it is eliminated, or that a certain amount is got rid of, before giving another dose, otherwise, with frequent doses, it will at length accumulate in the blood or the body. If you take a given amount of drug, you want to ensure that during a given interval a certain amount of it, at any rate, shall be eliminated, so that when you give another dose there shall not be so much added to what was previously given as to become poisonous. By giving such doses that, notwithstanding the intervals which elapse, the amounts overlap one another, there must be an accumulation. And that must happen with everything. It will happen with bread and butter and beef steak; and it will happen with opium, arsenic and other strong drugs; it will happen with iodide of potassium, a drug which is eliminated probably as fast as anything can be eliminated.

But what is stated is that Digitalis and Strychnine have a special cumulative action, and that the special feature of the cumulative action of Digitalis is—and we will admit it on the statement of physiologists—that it acts upon the kidney, by its action on the vessels, in such a way as to diminish the power of the kidney to eliminate it when given in increasing doses. Anything like a large dose of Digitalis diminishes the eliminating power of the kidney, and thus with repeated doses the eliminating power of successive intervals is more and more interfered with, and so the extra amount left uneliminated increases as time goes on. We may admit, therefore, that Digitalis has a special cumulative action.

But does that make a drug absolutely inadmissible over long periods of time? It does not seem to me that it does, because, however the power of the kidney may be affected by

Digitalis, it must be possible to give doses so small, that, with the intervals between the doses commonly adopted, they would not interfere prejudicially with elimination.

Does this cumulative effect really come into operation in the way above suggested? Speaking for myself, I do not know that I have ever known of a case where a cumulative action, operating in this way, has come into effect, after prolonged use of an average or small dose, and has killed the patient, or produced serious symptoms in a very short time. Now, there is one very good reason why in the ordinary way it should not come into operation, and it is a reason which seems to be rather overlooked. If you give medicine for a long period, the usual method is to give it three times a day. And the night interval is more than half a day; between six or seven o'clock in the evening, and nine or ten next morning, is an interval of fourteen or fifteen hours, and in that interval which elapses between the two or three doses given one day, and those given the next, there must be plenty of time to eliminate what extra amount has accumulated after the third dose. Whether for this reason or not, the experience of many observers has been against this serious effect of the cumulative operation of Digitalis.

Pereira, in his large work on Materia Medica (4th edition, vol. 2, 1855), says:—"I have used it and seen others employ it most extensively and in full doses, and have rarely seen any dangerous consequences, and I believe, therefore, the effects of accumulation to be much less frequent than the statements of authors of repute would lead us to expect."

Sir Henry Holland ("Medical Notes and Reflections," 3rd edition, 1855):—"I have frequently given Digitalis in the ordinary dose for weeks together, in combination with various forms of steel, and especially the tinctures, without finding cause to withdraw or intermit the medicine. Though employing the medicine somewhat largely in practice, I do not recollect a case in which I have distinctly seen injurious consequences from this cause, none such certainly as were not speedily relieved by its discontinuance, and other means of easy adoption."

The late Dr. Milner Fothergill, who had paid a good deal of attention to disease of the heart, and had done some original work on the action of Digitalis, says, in 1876:—"It has never fallen to my lot to see any evidence of the cumulative action of Digitalis." "In several instances known to me, notably in a case of my own, where Digitalis has been taken uninterruptedly for eight years, nothing bearing any resemblance to what has been described as the action of Digitalis has ever been seen. The cumulative action of Digitalis, as ordinarily described, has been greatly exaggerated."

Dr. Burney Yeo says of this drug:—'It is said to accumulate in the system, and after a time to produce sudden dangerous symptoms. After a long and considerable experience of its use in cardiac disease, we have rarely met with such a circumstance."

Dr. Whitla writes:—"Owing to the danger of accumulation taking place, the action of the drug should be watched for a week or two with care. As a rule, in moderate doses (5 to 10 minims) it may be administered for years without producing any unpleasant symptoms."

Dr. Lauder Brunton has written on the subject, and takes rather a somewhat different view of it. He says:—"As Digitalis is cumulative in its action, it is often advisable, after continuing it for several days, to leave it off for a day or two, and then re-commence." He recommends this for out-patient practice, "even when the dose is comparatively small."

My own experience is rather in accordance with the testimonies I read first. Even when such a dose as 5, or 7, or 10 minims is given three times a day, you can dismiss from your mind any fear or suspicion that the patient will suddenly drop down dead in consequence of the amount of Digitalis he has taken. The great probability is that the belief in the cumulative action of Digitalis originally arose from the occasional experience which everyone has heard of, namely, a patient with heart disease dying suddenly. If Digitalis is being taken, yet in spite of the Digitalis some accident may occur to the diseased heart, causing death.

It is also interesting to remember in this connection that at the time when the theory of cumulative action was started, the action of digitalis was differently understood from what it is now. At that time digitalis was believed to be a powerful cardiac sedative; it was given in cases in which the heart's action was excessive both in force and frequency, and it was considered to have the effect of beating the action of the heart down to a condition of quietude.

If we are not to be frightened by the conception or fact of a cumulative action when we are dealing with small doses given over long periods of time, neither need we be unduly alarmed when we are giving full and strong doses in order to get an immediate effect.

We will, again, allow that this special action of Digitalis in hindering its own elimination may be in operation. And why not? If you give the drug you want the effect of the drug, and the sooner the better: if the drug acts a little more quickly than the dose you give seems to represent, that is not a very serious thing. The patients suffering from heart disease, with whom you have to deal, must be watched and treated carefully, as must those suffering from other serious diseases. If you give a dose of Digitalis, you must learn by experience what is the dose that you may give with a reasonable anticipation that it will improve the condition of the heart, and will not produce any serious symptoms other than you may fairly expect, or, at any rate, which you cannot alleviate and stop by a cessation of the medicine. We are perfectly familiar with the fact that we have to give such remedies as opium, and arsenic, and brandy, and push them to their full effect, and that if we go beyond their full effect we are likely to do the patient harm. We do not refuse to give these drugs on that account; but we maintain a careful attitude; that is to say, we watch the effects and act in a suitable way when the effects we obtain are (*e.g.* from idiosyncrasy on the part of the patient) in excess of those that we want. If you give a full dose of Digitalis in a case where the patient's heart is beating rapidly, and the patient himself is very ill, and if the action of the drug is a little different after the fifth and sixth doses from what it was after the first and second, that is a contingency you can be prepared for. And so far as I know in regard to these cases, sudden death is not the result of such overaction of Digitalis, but certain symptoms which I will now refer to.

The symptoms you may get under these circumstances are the following, which I have, for convenience, taken from Pereira. Nausea, or actual vomiting, a slow and often irregular pulse, coldness of the extremities, syncope, or tendency to it, giddiness and confusion of vision; the sickness may be attended with purging or diuresis; but there may be neither vomiting nor purging. External objects appear of a green or yellow colour; there are mists and sparks before the eyes; and a sensation of weight, pain, and throbbing in the head, especially in the frontal region.

The symptoms I have myself chiefly noticed under these conditions are: nausea, very often actual sickness, headache, and a slow and irregular pulse with a good deal of violent, forcible action of the heart. Now if these symptoms come on when you are giving Digitalis, you can at once stop the dose of Digitalis for a time, and resume it under fresh conditions. If the drug has been already given for twenty-four or thirty-six hours, it is very likely that the distressing symptoms due to mitral disease will be much ameliorated or entirely gone. Please understand that I am not asking you to give Digitalis with the object of getting a toxic effect; I am saying that if you watch for evidence of its toxic effect it is an accident that is very easily met so that no material harm need result. I remember the following incident:—A clinical clerk wrote down a prescription from a physician's order, and instead of writing for *Infusion* of Digitalis, he ordered *Tincture* of Digitalis. The tincture is about eighteen times as strong as the infusion, and so you can imagine that the result was in excess of the anticipation of the physician. The mistake was soon rectified and no serious trouble followed. In any case with regard to Digitalis, the cumulative action need not materially interfere with you in your work if you watch its results and proportion the dose accordingly.

I may say that in very bad cases of heart disease where the patients are very ill, and have the characteristic symptoms of failure of compensation in a severe form, a full dose of Digitalis may be given, fifteen minims every four hours, or twenty minims or more even; and if its action is properly watched by the physician, the patient being visited two or three times a day, or watched by a skilled nurse who is constantly present, there is no harm in administering such a dose. If you do not give it, you are simply postponing unduly and unnecessarily the improvement of the patient. No doubt, with smaller amounts given less frequently, a good result may in five or six days be attained, but relief is desired much earlier than that, and if you are sufficiently courageous you can do it by giving the larger dose that is necessary.

I will conclude by making two observations in reference to the new Pharmacopœia. In the new Pharmacopœia the dose of Tincture of Digitalis is given as half of that in the old Pharmacopœia, and yet the strength of the two preparations is exactly the same. The strength of the Tincture of Digitalis in the old Pharmacopœia is 1 in 8, and in the new Pharmacopœia 1 in (?) 8. And the dose in the old Pharmacopœia is ten to thirty minims, and in the new Pharmacopœia five to fifteen.

I have been informed that the alteration is not due to any difference in the strength of the tincture (which as I have pointed out does not exist), but that the range of five to fifteen

minims was believed to represent more truly the limits of the usual and desirable dosage, than the old amounts ten to thirty minims. That, however, need not prevent a responsible and competent practitioner ordering twenty, or even thirty minims for a dose, if he feels and knows that the case really justifies such a step.

The other point is this:—The Tincture of Strophanthus appears to be weaker by half than it was.

When a tincture of Strophanthus was first proposed it had a strength of 1 in 10. This was soon found to be inconveniently strong, and it was reduced to 1 in 20, and these proportions were adopted when the tincture became official in the Additions to the British Pharmacopœia, 1890. Now it has a strength of 1 in 40; instead of 1 ounce of the drug to a pint of the tincture, there is only half an ounce; and the doses are from 5 to 15 minims instead of from 2 to 10 minims. I think that it was not always recognised that, dose for dose, the tincture of Strophanthus was a stronger drug than the tincture of Digitalis, and it is certainly convenient to have their therapeutical strengths approximated as they now are.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Pye-Smith.

Mary	25.	Exophthalmic goître.
	26.	Multiple ovarian papillomata. Ascites.
	27.	? Cystitis and pyelitis.
	29.	Mitral stenosis and regurgitation.
Philip	21.	Plumbism.
	24.	Pulmonary disease simulating phthisis.
	39.	Nephralgia.

Cases under Dr. Taylor.

Mary	38.	Disease of nervous system.
	40.	Exophthalmic goître.
	41.	? Empyema.
	42.	Gastric growth.
	43.	Jaundice.
	44.	Ascites.
	45.	Anæmia. ? Pernicious.
	47.	Anæmia. ? Leuchæmia.
Stephen	5.	Acromegaly.
	12.	Laryngeal obstruction. Tracheotomy.
	16.	? Renal growth.
	20.	Phthisis.

Cases under Dr. Hale White.

Mary	16.	Phthisis.
	20.	Mitral stenosis. Anasarca.
	21.	Cerebral tumour. Paresis of left arm. Trephined.
	24.	Acute rheumatism. Mitral constriction and regurgitation.
Philip	1.	Diabetes mellitus.
	2.	Jaundice. Enlarged liver. Malignant disease.
	4.	Nephritis. Sub-acute.
	6.	Cirrhosis. ? Granular kidney and dilated heart.
	7.	Aneurysm of aorta pressing on bronchus.
	8.	Jaundice. Carcinoma of liver.
	9.	Pleurisy and pneumonia.
	11.	? Cirrhosis.
	12.	Bronchiectasis.
	14.	Chorea.
	19.	Cirrhosis.

Cases under Dr. Pitt.

Mary	1.	Gastric ulcer.
	4.	Thrombosis of left innominate vein.
	7.	Chorea, maniacal, in an adult.
Stephen	22.	? Hydræa. ? Drug rash.
	23.	Anæmia. ? Chlorosis.
	26.	Acute pericarditis.
	29.	Chronic Bright (post-systolic bruit).
	30.	Emphysema with failing heart. Thoracic aneurysm.
	36.	Post-diphtheritic paralysis.
	39.	Diabetes mellitus.

"Clinical."

1. Pleuritic effusion.
2. Hydrochloric acid poisoning.
4. Aortic aneurysm.
5. Cerebellar abscess.
7. Appendical abscess.
9. Empyema.
11. Pneumonia. Pleuritic effusion. Cirrhosis of liver.
12. Localized myelitis.
15. Aortic and mitral regurgitation and incompetence.
16. Acute rheumatism. Pericarditis.
18. Empyema.
22. Cystic kidney.
24. Typhoid.
25. Typhoid. Broncho-pneumonia. ? Empyema.
27. Acute rheumatism. Pericarditis.
28. Hydatid of liver.
31. Exopthalmic goître.
32. Phthisis.
35. Meningitis.
36. Broncho-pneumonia.

Chapel News.

The response which has been made to the appeal for £90 to complete the central panel of the reredos has been most encouraging. Nearly the whole amount has been subscribed in little more than a month. The following donations have come in since the last issue of the Gazette :—

	£	s.	d.
Lady Byron	1	0	0
Miss Lambert	0	12	0
"A Guy's Woman"	0	10	0
Anonymous	0	10	0
Dr. G. E. Lockyer	0	5	0
Sister Stephen	0	5	0
Nurse Bayliss	0	2	6
"C.C.C."	0	1	0
Amount previously acknowledged	85	11	1
Total ...	£88	16	7

The three panels are now in their places, and no doubt many will take an early opportunity of visiting the chapel and judging for themselves of the effect. The central panel represents the Crucifixion, and the two side panels S. Luke and S. Barnabas, the patron saints of the medical and nursing professions. The artist, Mr. Percy Bacon, of Newman Street, has certainly produced something which harmonises admirably with the rest of the decoration of the sacrarium, and we think that the general verdict on his work will be favourable. If there are any who intend to give a donation and have not yet done so, they should send in their contributions without delay.

Mr. Sladen wishes it to be known that he has received an anonymous donation of £10 10s. towards laying down marble steps in the sacrarium, in the place of the present wooden ones. To do this would not cost very much, and would add greatly to the total effect. He hopes this gift will induce others to contribute likewise.

At the last meeting of the Church Council it was suggested that any surplus which may remain over from the Reredos Fund, after the panels have been paid for, should, with the consent of the donors, be devoted to this object.

Mr. Sladen would be glad to hear of any gentlemen who would sing the tenor and bass parts at the 11 a.m. and 7 p.m. services on Sundays. The choir practice is on Saturday evenings at 7.15 p.m.

The preacher on Sunday evening, May 7th, will be the Rev. Canon Taylor, Precentor of St. Saviour's Collegiate Church, and the preacher at the 11 o'clock service on Sunday, May 14th, will be the Rev. R. B. Rackham, of the Community of the Resurrection, Westminster and Mirfield.

Pupils' Physical Society.

The Annual Report of the Presidents of the Physical Society, read at the last meeting of the Society on March 18th, 1899.

The presidents of the Physical Society in presenting their annual report desire to express their hearty appreciation of the merit exhibited by the papers which have been read before the Society during this session. These papers have all attained an exceptionally high standard, and the society is to be congratulated on the fact that such valuable communications have been made to them. One paper was withdrawn through the unfortunate illness of the author, but the presidents are assured that he will take an early opportunity of contributing to the society's records. The meetings have been well attended throughout, and the discussions generally successful. As heretofore, the clinical evenings have proved the most attractive, and on each occasion there was an exhibition of a very instructive series of cases. It is with extreme regret that the presidents have to announce that there was no competition for the Treasurer's Prize, offered for an essay on "The Pathology of Jaundice." The secretary has, however, received a letter from the treasurer giving permission for the award of his prize to one of the readers of a paper before the society during the present session. The presidents desire that this generosity on the part of the treasurer should be specially acknowledged.

At the final meeting of the society it is customary to announce the distribution of the prizes. An exception, however, must be made to-night, because the adjudication committee have not had sufficient time to complete their report. It has, therefore, been decided that the announcement of the prizes shall be published in the Gazette.

The following gentlemen are invited to join the board of presidents of the society for the ensuing year :—Messrs. Bruce, Davies, Hilton, Meachen, Milton, and F. E. Walker.

In conclusion, the presidents venture to think that all concerned in the management of the society may regard with satisfaction the work of the session which closes this evening.

Pass List.

University of Cambridge.

Examination in Sanitary Science, April, 1899.

The following candidates have satisfied the Examiners in Both Parts of the Examination :—

Stanley Copley, E. L. Parry-Edwards, H. J. Spon, C. M. Vernon.

Nursing on the Niger.

In response to an appeal for some notes on work in West Africa, Nurse Powell has sent us the following short account, more in the nature of reminiscence than actual connected history. On asking for more we were told that many amusing incidents occurred, but that they would be better told by Dr. Wordsworth Poole when he returned, so we must be content with what we have got.

Dear Mr. Editor,—You have asked me to give you a rough idea of our experiences in West Africa. Rather a difficult thing to do; however, I will do my best. I will not weary you with an account of our voyage; that was very matter-of-fact.

On our arrival at Forcados we embarked on a small steam launch, with only a native crew, so of course we were not at all nervous. After four and a-half days we reached Lokoja. Arrived there, we were quartered in a house belonging to the Niger Company, as there was no house ready for us. All in camp were living in tents. The hospital was a grass hut. After a few weeks a temporary hospital is put up in camp so we take up our quarters in one room of it.

Do not imagine the temporary hospital is the size of Guy's, oh dear no, it is only a wooden hut of three rooms, each room contains two beds. However, it was a great improvement on the grass hospital.

After about four months our proper hospital of twelve beds was put up. We really felt then that we had settled down, and so we did for quite three months, then we had orders to go up to Tebba, another 300 miles higher up the Niger.

There we found a hospital of six beds. Of course they were nearly always occupied. The cases we had to nurse were malaria and black-water fever, dysentery, with a few boils thrown in as a change. Operations were few and far between, our largest one being, if I remember right, amputation of leg (black boy). We had a good many deaths from fever the first few months, it being the unhealthy season.

From Christmas until we left we had not one, though I have since heard four died in one week soon after we came away. Black-water fever was much more prevalent at Tebba than Lokoja, and though we had several very bad cases we fortunately lost only one.

Our hospital servants were, of course, black boys, and very funny they were too. We never could make them understand how to make beds, and they had a most delightful habit of smiling at you (after you had wasted your breath a good five minutes scolding them) and saying "I no sabe."

Most of the natives were very friendly and very proud of the few English words they picked up, though they usually used them in the wrong place, for instance: A native soldier one evening was walking along talking to himself. When we were near enough to hear what he was saying, we found he was trying to impress on his mind words I am sure he could not have heard a white man say—D —— m fool.

Our own black boy was often very funny. If we had fever, he used to say, "You sick, you take blanket, go for bed." After about two days he would say, "Sick all finished, you quite strong now."

I think I have taken up enough of your valuable time. There are heaps more I might tell you, things which at the time were only too real, though now we can afford to laugh at them. Discretion is the better part of valour, if I tell you all, well, you might think it not quite true.

We have also to thank Nurse Powell for the accompanying photographs.

Notice.

Hospital for Consumption and Diseases of the Chest, Brompton.—Summer Session, 1899.

Lectures and Demonstrations (Wednesdays, at 4 p.m.)

May 10. The Clinical Investigation of Chest Cases. Dr. Frederick Roberts.
„ 17. Some Cases of Actinomycosis. Mr. Godlee.
„ 24. Hæmoptysis. Dr. Green.
„ 31. Mitral Regurgitation. Dr. Maguire.
June 7. The Arrest of Pulmonary Tuberculosis. Dr. Fowler.
„ 14. Mediastinal Tumours. Dr. Sidney Martin, F.R.S.
„ 21. Asthma. Dr. Schorstein.
„ 28. The Diagnosis of Pneumothorax. Dr. Habershon.

The lectures are free to all qualified medical practitioners, and to students attending the practice of the hospital.

From the Gazette's Special Pathologist.

E. R. M., Hastings.—No tubercle bacilli can be found in the sputum.

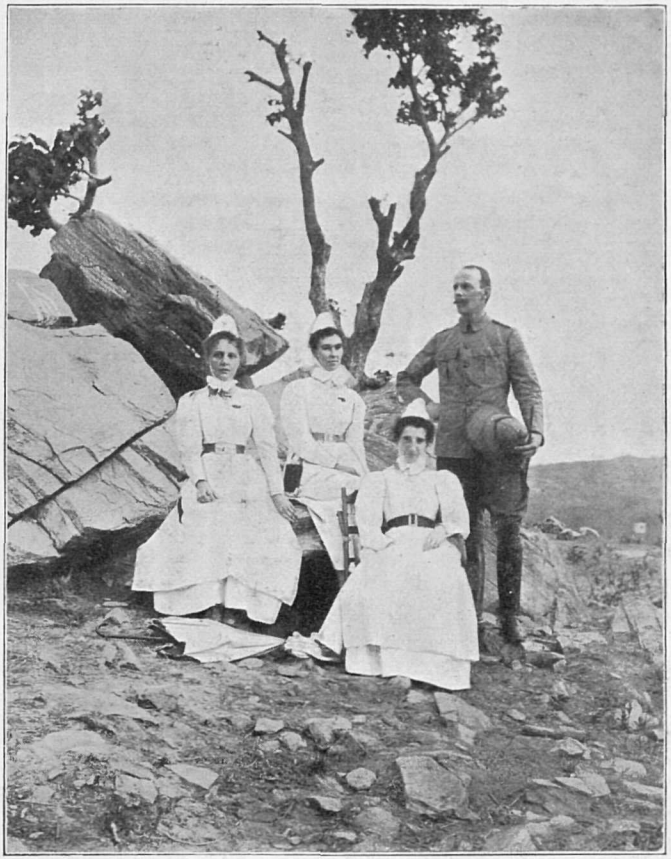
H. V. H., Wanstead.—Reaction faintly acid. Sp. gr. 1019. Albumen, blood and sugar absent. Microscopic examination: The centrifugalized deposit is almost wholly crystalline, consisting of crystals of stellar phosphate and calcic oxalate, the latter only in small quantities. There are a few vesical cells, but no casts or renal epithelium were detected.

C. P., Barton-under-Needwood.—Tubercle bacilli are present in the sputum in small numbers.

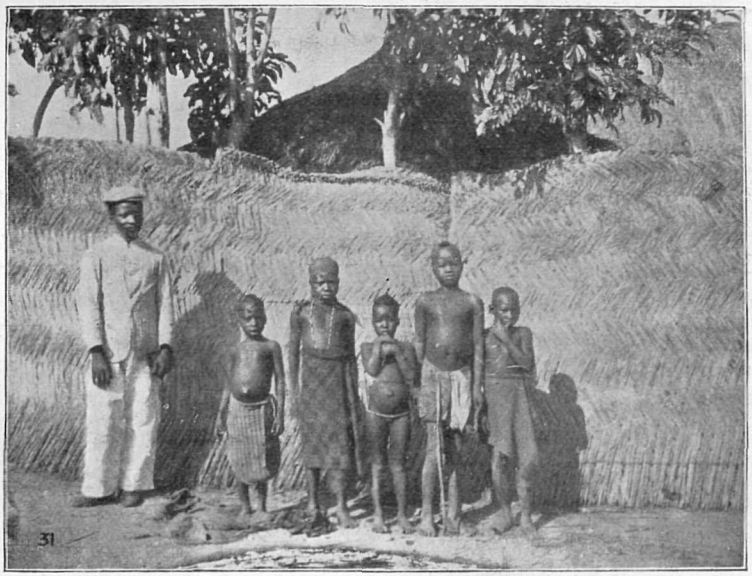
PATHOLOGIST.

Papers by Guy's Men.

Remarks upon Exploratory Operations upon the Stomach for Obscure and Obstinate Gastric Symptoms. Illustrated by a case Gastrorrhaphy for Dilated Stomach. By A. Ernest Maylard, M.B., B.S. Lond. *Lancet*, 8th April.



NURSE NUTT.
NURSE POWELL. NURSE CLARKE.



Passim.

The Annual General Meeting of the Students' Club will be held on Monday next, May 8th, in the Anatomical theatre at 4·15 p.m.; Dr. Pye-Smith will be the chairman.

A well-known old Guy's man has just passed away in the person of Charles L. Prince, Esq., M.R.C.S., of Crowborough, Tunbridge Wells. He was a student at Guy's in the early forties, and qualified in 1843. His chief interest in life, however, was not so much the art of medicine as the science of astronomy, and in his obituary notice in the *Times*, no fewer than six original papers on astronomical and meteorological questions are noted. During the prevalence of rabies in 1874, Mr. Prince purchased at great expense an ancient recipe, which was said to be a cure for hydrophobia, and at once published the ingredients in the medical papers. The results of this treatment were evidently not far-reaching.

At a meeting of the Presidents of the Physical Society held on Thursday, April 29th, the prizes for the session were awarded as follows:—The first and second prizes were divided equally between Messrs. H. W. Bruce and F. E. Walker, for their respective papers, "Plague Work in India," and "The Treatment of Burns and Scalds." The Treasurer's prize was awarded to Mr. W. T. Milton, whose paper on "Hæmorrhagic Pancreatitis" was placed third in order of merit.

We are glad to notice that occasionally a few words go a long way. In response to an appeal in the last number of the Gazette for more keenness in the direction of tennis comes the news that it is proposed to run a 2nd VI. this year. F. E. Fremantle has been elected captain and match secretary. We are informed that one of the chief ideas is to meet the other hospitals, and an attempt is being made to arrange matches for every Saturday. It has also been decided to start a Doubles handicap this year.

Some few weeks ago the date of the weekly meeting of the House Committee was altered from Wednesday to Thursday morning. Matters have now been made more symmetrical by the alteration of the commencement of the Take-In Week from Wednesday to Thursday. Also the take-in starts at 9.30 a.m. instead of 10 o'clock as heretofore. This last is certainly an improvement, as it does away with that well-known awkward half-hour from 9.30 to 10 on the last day of take-in, when the dressers of the going-off firm do not want to get up to the hospital by half-past nine only to dress for half-an-hour, and the dressers for the week refuse to leave their beds. The situation as a rule resolved itself into the Assistant House-Surgeon dressing in both Surgeries himself.

About a year ago an appeal was made in the pages of the Gazette, for the more liberal communication of interesting clinical cases. There are eight senior men acting as clinical assistants in the surgical and medical wards, and six embryo Galens in Clinical, and not one of them without much persuasion will even send a line to the Gazette, so that others may read of it. To the outside public of Guy's men who read the Gazette, the local news, unless it tells its own story, or is in itself interesting, is of little moment; what they want to know is what good cases there are in the hospital, and what is being done in the way of treatment.

It was with this end in view that the Gazette at the commencement of the Session commenced to publish clinical lectures more fully and with more regularity. We would again appeal to all senior men in the wards to send us concise accounts of interesting cases, paying, if possible, great attention to the treatment or the opinions expressed by the physician or surgeon in charge.

Last week there was a great anti-vivisection meeting at St. James's Hall. Of the speeches on that occasion the less said the better; they have no interest for intelligent men. But we should like to congratulate the *London Hospital Gazette* upon a very trenchant editorial, in which they exposed what is perhaps by now well known, the intentional suppression by the Chair at that meeting of speakers of the opposite opinion and the usual tissue of "inaccuracies" and hysterical abuse of the profession. The men at the London have our deeper sympathy in that quite recently their hospital was the victim of a most malignant attack by the anti-vivisectionists, who, as is their wont, when their allegations were refuted, left apology unnoticed.

At a General Meeting of the Cricket Club on March 21st, the officers for the present season were elected. The president is Dr. Brailey, and

the hon. sec. and treasurer is G. T. Willan. K. V. Trubshaw will captain the eleven this year. The first match v. Waldegrave Park will take place to-day at Honor Oak Park, where the ground is now in fairly good condition.

"DERMATOLOGY."—"Rather like a secondary," said the H.P.; "but no other signs. Perhaps he's been taking iodides." "Nothing like secondary is it?" said the A.H.S. "Ten to one it's a G.O.K." "Drug-rash," said the Registrar; "perhaps he's been taking Copaiva." "Secondary," said two more H.P.'s. "Obviously not a secondary," said Physician A.; "Probably Hydroa Herpetiforme." "Don't know much about Hydroa," said Physician B.; "looks like secondary; ask Physician C." "Lues is it," says Physician C. And the Hydroa man is left to say the last word next Wednesday.

JUST as we go to press we hear that among others the Council of the Royal Society has recommended Dr. Ernest Starling for election as a Fellow. We hope that his election will follow as a matter of course. Anyhow, he is to be most heartily congratulated upon the distinction.

Burns and Scalds.

A paper read before the Physical Society on Saturday, February 4th, 1899, by Mr. F. E. WALKER.

(Concluded.)

There is not very much to say concerning the stage succeeding shock, namely, reaction; but the great majority of severe burns which are not fatal within thirty-six hours exhibit this condition. The temperature rises to something over 100°, and the pulse correspondingly quickens. Hyperpyrexia supervenes fairly frequently. Of the afore-mentioned 224 cases, 13 developed a temperature of 105° or over, and 12 of these proved fatal, the majority of them on the second, third or fourth day, two as late as the twenty-third and forty-fourth days. In five of these cases broncho-pneumonia was present, three of them persistently vomited, and one had inflammation of all the serous membranes. The one case of hyperpyrexia that got well (a case under Mr. Lucas in 1894) had symptoms of broncho-pneumonia, severe diarrhœa and vomiting, and developed on the fourth day a profuse septic rash. Dr. Bryant (Guy's Hospital Reports, 1893), writing on hyperpyrexia, records that he examined 803 reports of burns and scalds (admitted between 1881 and 1893), and in these he only found temperatures above 106° in six instances; five of these were fatal. The highest temperatures recorded were 109·8°, 108° (twice), 107·2° (the non-fatal case), 106·4° and 106·2°. The case that recovered was treated with Quinine Sulphate gr. v. when the temperature was highest, followed by two grains every three hours. The patient was a girl aged thirteen, and the only part affected was the left leg as high as the knee; probably another case of septic absorption. He believes that the hyperpyrexia may be explained in two ways—(1) By septic absorption; (2) by reflex stimulation or inhibition of the thermal centres, probably the thermotaxic mechanism. Dr. Hale White suggests the latter view in his address on Pyrexia at British Medical Association, 1894.

The complications of burns as given in the books, when set down on paper, form a pretty formidable list; but judging only from the cases admitted into this hospital during 1894 and 1897, the list is considerably shortened. During those years the reports record that 66 out of the 224 cases had one or more complications, about every fourth case. And in speaking of complications, I am not including shock and collapse, for these are at present an essential part of every severe burn, and, of course, it is only severe burns that are taken into our wards.

Vomiting is recorded in sixteen of the cases. Out of these fourteen died. Making all due allowances for omissions on the part of the reporters, the conclusion must be drawn that this symptom is one of the most fatal that can occur. The vomiting usually comes on rapidly, within twenty-four hours of the accident. Sometimes almost immediately, but in one case it was delayed for forty-eight hours, and it lasts usually till death. In some of the cases the vomiting preceded death so shortly as to seem almost part of the dying process.

Broncho-pneumonia occurred in nine cases. In seven of these death followed. In four instances it was diagnosed on the third day, but in the remainder no mention is made of it until after the ninth day. All the cases with early onset died, and all had hyperpyrexia. Of the nine cases, eight were children under three.

Severe diarrhœa complicated six cases and all six died at or about the third day. Vomiting occurred as well in four of these.

Four small children had *convulsions*, all fatal, death occurring in two instances within the first twenty-four hours, and in the others on the third and fourth days. One child of two was quite unconscious for two days and then died.

Sapræmia and septicæmia are recorded as occurring in eight cases, and four ended fatally, the deaths occurring on the fourth, tenth, twelfth, and fifteenth days. And this leads to the subject of the rashes met with in burns.

Eruptions of one kind or another are recorded in fourteen of the 224 cases. Of these, four were diagnosed scarlatina and sent off to the fever hospital, one was the rash of erysipelas, one that of measles, and the remaining eight septic. The large proportion of scarlatina rashes led one to enquire whether these were really true scarlet

fever cases, or only septic rashes resembling that of the true fever. Dr. Gayton (now of the N. W. F. H.), who has had as much experience of fever hospitals perhaps as any man in London, told me that twenty-nine surgical cases were admitted to the Eastern Fever Hospital in one year. Of these, six were burns, and this is about the yearly average. Now, at Guy's, only one case in forty-seven surgical cases is a burn. So that there is considerable disproportion between the two sets of figures. However, Dr. Gayton stated that the large majority of these cases sent to the Fever Hospitals had true scarlatina, for not only were most of the symptoms present, but the children did not afterwards develop the disease. The special characteristics of scarlet fever occurring in a case of burn are:—A short incubation period, an atypical rash, and marked nervous symptoms. The large proportion of scarlet fever cases has been explained by one ingenious theorist as due to the fact that children sickening for scarlet fever would probably feel chilly, and being at the same time unsteady on their legs might very well stumble towards and into the fireplace. The true reason is probably that the large raw absorbing surface offers special attractions to the hypothetical scarlatina microbe. As regards the septic rashes, the striking feature about them is their anomaly. In no case was the body covered all over. The lower limbs, especially the thighs, seems to be the most favoured situation for it to appear, but it occurred on the face alone, on the back, or on the abdomen, and in one instance was situated close to the burnt area and nowhere else. In character, but not in distribution, it may resemble the rash of morbilli, rubeola or scarlatina, the morbilliform being the most common, judging from the reports. In one case the rash was intensely itchy. Half the rashes occurred in cases that ultimately died. The date of appearance of the rash varied from the second to the twenty-seventh day. More than half, it appeared before the sixth day.

These, then, were the commonest of the complications met with in this series of cases. A few others, too rare for lengthy notice, also occurred. One woman, who happened to be five months pregnant at the time of the injury, aborted on the eighth day. One case died on the sixth day, apparently of uræmia. Melæna was observed once. This case died, but no ulceration of the alimentary canal was found. Five cases only came back afterwards for contraction of the scar. In all probability there were more, but I was unable to find them. Extensive keloid developed in one scar, and was excised. Palsy of the right median nerve, possibly, I suppose, due to septic neuritis, occurred in one case. It came on very soon after the receipt of the injury One woman died more from her phthisis than her burn. One case, which I briefly alluded to when speaking of rashes, developed fatal erysipelas on the ninth day.

Just briefly comparing these with the complications recorded twenty years ago, the only striking difference is the number of cases in which marked contraction of the scar occurred. In 15 of those 122 cases this is recorded—over five times as often—but the longer stay in the hospital in those days must be remembered. Nowadays many go out before the cicatrix begins to contract up. Tetanus occurred three times, in all cases with fatal results, on the ninth, tenth and eleventh days. Remembering the incubation period to be nine days, one can speculate that perhaps a vigorous cleansing of the wounds at the time of admission might just have averted the disasters. Carboluria was then of somewhat frequent occurrence, and hæmaturia occurred twice.

Turning now to by far the most important part of the subject—I refer, of course, to the Treatment—I will, with your permission, dwell chiefly upon the question of local treatment, for I do not think I need enter much into details as regards the general policy to be adopted. The indications for supporting and stimulating treatment are now so well understood and accepted, that every dresser must be familiar with them. With reference to shock, authorities are agreed, and a good deal can be done to lessen its disastrous effects, if not to prevent them altogether. And for this, the position of the patient is of considerable importance. Goltz showed, after paralysing the abdominal vessels of a frog by a tap on the belly-wall, that the heart, which re-commenced beating if the lower limbs were placed horizontal or held up, would not do so if they were allowed to hang vertically. Therefore, a patient should be kept horizontal, with the head low and the limbs raised, thus facilitating the return of the blood to the heart. The result may be augmented by tightly bandaging the abdomen if circumstances permit, but watching carefully the while that the heart is not embarrassed by so doing. The patient *must* be kept warm. If the usual hot bottles and flannels do not do this, recourse must be had to hot baths. Alcohol and ammonia are the most useful stimulants we have. Contrary to the general belief, strychnine, oxygen and atropin have in cases of severe shock little or no effect. Digitalis is warmly recommended by Dr. Lauder Brunton. Opium, of course, is indicated for the pain.

One other point as to stimulants. We must not be over zealous in their administration. Patients in a state of shock have often been observed to fail to respond at all to the powers of strychnine, opium, or alcohol, but have afterwards exhibited well marked symptoms of poisoning, if the drugs have been given in large quantities. The arrest of their action in shock has been attributed to the want of absorptive powers on the part of the tissues. John Hunter, Brown-Sequard, and more recently M. Roger, observed that in animals in whom shock had been experimentally produced, the blood in the veins was of a bright red instead of a dark colour. This M. Roger attributes to the arrest of the exchanges which normally go on between the blood and the tissues, and the consequent presence in the venous blood of a greater percentage of oxygen than normal. A frog, too, which had had its head crushed, did not react to strychnine at once but did so after some hours, presumably when the first effects of shock had passed off, and then promptly had a spasm and died. I have never heard of a fatal case

resulting from the over-administration of stimulants in burns; still, if, as we all hope, the terribly large mortality of burns is ever in consequence of improved treatment, somewhat lessened, this catastrophe might easily occur, and so it is just worth consideration.

For collapse, I have mentioned the intravenous injection of salt solution as seemingly the only rational treatment if the causation of the slack is, as is believed, due to the increase in the specific gravity of the blood. But in practice this produces only temporary good, reducing the specific gravity for a short time only, which in an hour or two is as light as before. Sherrington and Copeman have shown that injections of sugar solutions answer the requirements better, producing a more lasting effect. But more experimental evidence of its value is necessary before it can be safely and generally used. In the collapse due to profuse diarrhœa, an attempt should be made to make up somewhat for the great loss of fluid by the administration of plenty of water by mouth and rectum. One authority has recently been advocating the subcutaneous injection of sheep's serum for the prevention of collapse.

Coming now to the all important local treatment. There are obviously two parts to the subject, I. What to use. II. How to use it. And the second part is far and away the more important consideration. To put the whole matter in a nutshell, one word is sufficient, and that word is cleanliness, by which is meant of course, not what is popularly termed cleanliness, but what is understood as surgical cleanliness. For here we have given us a wounded, often extensive surface, which by the mere method of its production has a tendency to be in itself aseptic, but which if neglected or maltreated, offers infinite possibilities for the gambols of the ubiquitous microbe, which if allowed free play, must of necessity put to serious risk, perhaps to an end, the life of the patient, or anyhow will incapacitate for a longer or shorter period an individual who might, but for the injury, be proving himself a useful member of society.

Twenty years ago Carron oil, which I have mentioned was first introduced at the beginning of the century and which—to the disgrace of the profession be it said—has held universal sway up to quite recent times, is mentioned as having been used in over half the reports of cases of burns admitted to this hospital. In well over a third of the cases no other treatment whatever is mentioned—Carron oil day after day, quite irrespective of the degree or condition of the burn. But it may be asked what was used on the remainder of the cases. In nearly a third of the reports no treatment whatever is put down. In the remaining cases, carbolic oil was used eleven times, zinc ointment seven times, lead lotion five times, and olive oil alone four times. Here and there I came across variations in the usual treatment, usually for a day or two only. Thus, carbolic lotion, resin ointment, silver nitrate lotion, chloral lotion, Condy's fluid, are mentioned, not to speak of lime-juice, warm flannels, water pure and simple, steam and oil rags. In recent literature the merits of many substances have been vaunted, chiefly for burns of the first and second degree; among these are ointment of galls, potassium nitrate and magnesia, hazeline, bismuth carbonate, Aristol (an iodised thymol), picric acid. One man advocated in the *Lancet*, 1896, the employment of a kind of antiseptic cage with no immediate application to the burnt surface. Through this cage he later took to passing oxygen gas, he said, with good results. Quite recently I saw sterilised milk mentioned as a good application.

In Germany, the country *par excellence* of asepsis, one would expect to find a rigid cleansing method in vogue. As far as I could make out, the following are the chief points in this method of treating burns and scalds over there. The injured surface is carefully cleaned and subsequently irrigated with either 3 per cent. carbolic lotion or 30 per cent. salicylic acid solution. If blebs are present they are then snipped. The whole surface is then sprinkled with powdered bismuth. Over this absorbent cotton wool is liberally placed to take up the discharge and to protect from the air. The wool is sometimes sprinkled with equal parts of bismuth and starch. This dressing is left on for from one to three weeks. Von Bardeleben (who is a warm advocate of this method) says that he has seen burns of two-thirds the body-surface recover under this treatment. He believes that the bismuth prevents intestinal complications, as in 100 cases only two had melæna.

In France, the general custom is to apply straightway on lint a lotion consisting of carbolic acid, glycerin and distilled water (about ʒi. of carbolic to the pint), and leave this on till all the blebs are formed, presumably for twelve hours or so, and then to puncture them and apply iodoform and vaseline (ʒi. in x. about). There must be obviously a certain amount of risk in this method of carbolic and iodoform poisoning.

Coming nearer home, the treatment at the London Hospital, as described by one of their house-surgeons recently in the *Lancet*, is as follows:—"The child is wrapped in a blanket just as it is, secured with pins round the neck and chest. Hot water tins are placed in bed with it, the bed itself being screened off in front of the fire. Brandy and opium are given at once, and the patient is not dressed until well under the influence of the latter. Four to five minims of the tincture are given to a child of two or three. If the child is crying at the end of an hour, another three to four minims are given. When the child wakes, one part after another of the burnt surface is exposed and dressed with zinc ointment and cotton wool. This dressing is left on till the fourth day. The three or four days which follow are spent in preparation for the drain of suppuration. Tinct. opii ♏ii. every four hours, 30 ♏. brandy every hour, and as much food as the child will take, are given. When suppuration sets in, daily dressing and plenteous food is relied on to carry the child through, diarrhœa being vigorously combated with carbonate of bismuth and more laudanum."

I wrote to a Thomas's house-surgeon I happened to know, and asked him what methods they adopted there. He told me that for burns of the first degree they used lotio plumbi or lotio plumbi evaporans, or else some powder such as starch and bismuth—this especially for the face. For burns of the second degree, cold boracic lotion was chiefly used, and for the more severe burns, hot boracic lotion frequently renewed or else the boracic bath.

A University College Hospital house-surgeon told me that their treatment of superficial burns is much the same, an ointment of equal parts of lanoline and olive oil being a favourite one. For second degree burns they use boracic ointment spread on wool. For burns of third degree and over, when possible, they always use the boracic bath at 99° to 101° F., the lotion being constantly renewed. If the bath is not available they use boracic ointment extra thickly spread. The constitutional treatment adopted differed in no particular from the usual.

Coming back to our own hospital, I need hardly state that the ointment consisting of equal parts of our boracic ointment and vaseline, spread fairly thickly on ordinary lint, and known as burn—not burnt—dressing, has been for the last few years, and in fact still is, the favourite application.

Of the 224 reports to which I have before referred, in 29 of them no mention of the treatment adopted or application used is made. In 128 of the remaining 195, spread boracic only was used. In 27 others it was used in conjunction with boracic fomentations or baths. In the remaining 30 odd it was varied occasionally with some one of the ointments, powders, or lotions that I have already mentioned. Of the fatal cases, considerably over one-half were treated with burn dressing only, and in many of the reports there is no mention whatever of any attempt at cleaning the injured surface previous to its application.

As regards the method of application of the remedies at Guy's, I need say little. It is customary to make some attempt at cleansing the burnt surface, warm boracic lotion being the favourite liquid for the purpose, lint soaked in this being gently drawn over the surface. The dressing is then applied, with wool bandage over. Next day the dressing is renewed, or if thought necessary fomentations are applied, and so on until the wound is healed. If very extensive, as soon as may be grafting is resorted to.

Now, it seems to me that all these methods of treatment come short in one respect or another. In some, *e g.*, in the method in vogue at the London Hospital, the local treatment is sacrificed to the constitutional. The patient is left to itself for hours, until well under the influence of opium (which is not even given hypodermically) before the local treatment is begun. And with what result? They have to prepare, as a matter of course, for "the drain of suppuration." To my mind it shows a pitiable failure to grasp the principles of aseptic and antiseptic surgery when one has to use such phrases. Our own method of treatment seems to me to fail because it is not sufficiently drastic from the beginning.

What is wanted is a method that will combine the maximum of surgical cleanliness with the minimum addition to the amount of shock that the patient has already received before coming under our care. To fulfil these qualifications the method must be speedy, must entail as little exposure of the child as possible, and the fewer subsequent dressings to the first one the better.

Now, everything depends on the immediate treatment of the injury. By far the greater number of burns come to the hospital within half-an-hour of the time of the accident, and as was stated when discussing the question of shock, the greater number certainly do not exhibit immediately on admission the symptoms which the books tell us are diagnostic of that condition, although without doubt shock subsequently may supervene. This, then, is the time that should be seized upon to thoroughly initiate the local treatment, taking care meanwhile that the constitutional is not forgotten.

And this brings me to the question of giving an anæsthetic to a case of severe burn. There is no doubt, whatever, that it is absolutely impossible to thoroughly cleanse an excessive dirty surface with the patient conscious all the while. Moreover, it is quite on the cards that, if we try to do so, shock and exhaustion will be more speedily induced, especially when we remember that we are dealing with small children, in the majority of cases, who have not the same power of resistance as regards pain as have adults.

This question of the advisability of an anæsthetic immediately or soon after the receipt of the injury, is a very important one. Hewitt, in his anæsthetics and their administration, says, in discussing the general condition of the patient, that when there is a rapid pulse due to shock, exhaustion, etc., an increase of rate will usually be found to occur. Such patients are very susceptible to anæsthetics, small quantities only being necessary to induce and maintain anæsthesia. As a general rule the pulse of an exhausted patient improves in volume when anæsthesia is established, but directly the anæsthetic is withdrawn, some depression of the circulation may follow. Moreover, this initial improvement does not as a rule last long, and any prolonged exposure or severe surgical procedure will soon give rise to signs of circulatory depression. The administrator must do all in his power to sustain the strength of these patients. Should the heart's action be very feeble, no method of administration should be employed by which the supply of air is greatly restricted. Ether is as a rule the best anæsthetic, and best administered by the open method, and in small quantities at a time. Should a close inhaler be used, care must be taken to remove it frequently for the admission of air. He makes the general conclusion, that although patients with embarrassed and feeble cardiac action take anæsthetics, as a general rule, remarkably well, they are nevertheless not in such a favourable condition to withstand any prolonged or severe strain upon the heart as patients with a healthier circulation.

That is what Hewitt says, and I take it that his verdict is that anæsthetics in shock are contraindicated only if *the surgical procedure is to be very lengthy, or the* patient in very bad condition from the beginning, but that if care be taken in slight cases of shock there is no definite objection. If, then, as I would maintain, the greater number of the patients are not suffering from shock at the time of admission, there seems to be no earthly reason why an anæsthetic should not be given.

Yet what do we find. During the four years 1894–97 in one case *only*, a woman of 55 who came in under Mr. Howse in 1895, very extensively burnt on the legs, abdomen and buttocks, was an anæsthetic given within twenty-four hours of the receipt of the injury—(of course there were several to which anæsthetics were given later for grafting purposes, etc., but that is quite another question). The burn was so severe, that this woman died in spite of all that could be done.

It was not until 1898 that a systematic attempt was *made to determine the value or otherwise of giving an* anæsthetic to cases of severe burn immediately, or as soon as possible, after they were admitted to the hospital. Mr. Howard, at that time Mr. Lucas' house-surgeon, treated in this way all the six cases admitted during his term of office. Of these six, only one died. May I recall to your memory a statement that I have already made, that the mortality of burns admitted to this hospital of recent years has been at the rate of one in three.

Here is a brief account of these cases :—

I.—H. S., æt. 3. Admitted February 2nd for scald. Brought up some hours after the accident. On admission, pulse 120, respiration 44. Semi-collapsed. Scald superficial, extending from the back of the neck to the gluteal region, involving the whole back, also anterior surface of neck, arm and thorax on right side. All of second degree. Given ether, washed thoroughly with lysol, and dressed with picric acid solution on sterilized pads. Dressed again second day, then on eighth day. On eleventh day the wound looked so much better that ointment alone was used. Pulse kept at or about 120 during the whole stay in hospital. Went home healed on twenth-fifth day.

II.—M. F., æt. 5. Admitted February 23rd for burn on back and legs. On admission, found to be badly burnt over whole of the lower part of the back, thighs and buttocks, and both legs. A.C.E., followed by ether, was given ; the wound carefully cleansed with soft soap, lysol and formalin ; dressed with picric acid on sterilized lint. Next day temperature sub-normal ; pulse 112 later 152. Given strychnine, morphia and brandy, but died within thirty-six hours of admission, without ever having rallied since the time of injury.

III.—E. B., æt. 4. Admitted February 26th for burn. On admission, patient could not be roused to answer questions. Extensive burn of second degree over front and right side of abdomen and right thigh down to knee —partly of third degree. Also on chin and neck, front of right upper extremity down to the thumb, and slightly on the right side of the face. Ether was given at once and the burn scrubbed with lysol and turpentine ; dressed with lint soaked in picric acid. Given I.M.H. gr $\frac{1}{12}$. P. Doveri gr. iii. *6tis horis. Four hours after* admission, temperature 98°, pulse 136, respiration 28. On third day, temperature 99·2°, pulse 130, respiration 28. On fifth day, temperature 101°. On seventh day, hot fomentations. On ninth day, temperature 99° ; after that, normal. On twelfth day, grafted, and again on twentieth day. Discharged during eighth week.

IV.—A. N. æt. $1\frac{1}{2}$. Admitted March 25th for scald. On admission not at all collapsed, crying vigorously. Burn of second degree all over front of chest, left shoulder, arm and neck. Given ether. Washed with turpentine and lysol. Dressed with lint soaked in picric acid. Given Dover's powder. Temperature next day 101°, then gradually down to normal ; pulse, highest rate 140— afterwards kept about 124. Discharged on twelfth day.

V.—A. K., æt. 19. Admitted March 28th for burn. On admission dazed and somewhat collapsed. Temperature 99° ; pulse 90. Burn partly of fourth degree over whole of dorsal surface of thorax. Also right side of chest, backs of the arms, and in both axillæ. A. C. E. was given half-hour after admission. Burn washed with turpentine, soft soap, and lysol ; swilled with formalin. Dressed with lint soaked in picric acid. Pulse, after operation, 84. I.M.H. gr. $\frac{1}{4}$, Pulv. Doveri gr. v., 4tis horis. Some pain for two days. Third day temperature 102°, pulse 100. Dressed on fifth day. Hot boracic for four days and then grafted. Discharged during fifth week.

VI.—A. C., 3. Admitted June 26th for scald. On admission, scald second degree from umbilicus to knee, small patches of third degree. Ether given. Temperature at time 103·2° ; pulse 120 ; respiration 30. Cleaned up and picric acid applied. Dressed next day and again three days after. Temperature reached 100° for the first three days, then fell ; pulse, second day, 120. Thirteen days after injury the report says, scald on left thigh quite well. On right thigh small granulating surface. On nineteenth day the child was sent home almost healed.

I have not looked up the reports of cases admitted since last June, so that I cannot tell for certain whether this innovation has been kept up, but so far as I know it has not been.

Anæsthetic or no anæsthetic it is essential that the burnt surface should be rendered absolutely clean. If the patient be under the influence of ether, there is no objection to gently scrubbing the tissues with a clean nailbrush, with turpentine first to get rid of all greasy material, and then with 20 per cent. lysol—a far more convenient and efficient lotion than either carbolic or perchloride of mercury. After the thorough use of lysol, the surface may be with advantage swilled with weak formalin, say 1·500, which although possessing equally strong antiseptic properties—if freshly made up—is perhaps less harmful to the tissues generally. It should not, however, be substituted entirely for lysol, as no lotion that we at present have can touch that for general

cleansing purposes, its alkaline properties making it so extremely efficacious.

I have spoken pretty strongly respecting the thorough cleansing required, but care must, of course, be taken that the process is not carried to excess. The possibility of doing damage to healthy tissues by excessive use of antiseptics must always be borne in mind, and in a few cases—but not many—the use of the scrubbing brush will be contra-indicated.

The general condition of the child, the dirtiness or otherwise of the wounded area, added to the experiences gained by the treatment of other cases must be our main guides. At present more harm is done by too little than by too much cleaning up.

To effectively carry out this treatment it will be understood that in most cases it will be far better to take the patient to the theatre or ward. There is no reason why the general precautions of ordinary operations should be in any way relaxed. It is exceptional at the present time for a dresser to thoroughly scrub his hands and so forth when about to dress a burn, yet why shouldn't he? He is about to deal with a far more extensive absorbing surface than is met with in most operations. The patient must be exposed only as much and for as long a time as is absolutely necessary. The temperature of the operating room is important, and for this reason, if for no other, the front surgery is to be avoided if the burn is extensive. A temperature of 80° F. is not a bit too high if it can be obtained. The operation ought to be well over in half-an-hour or so, so that the operators should be able to stand a little inconvenience for such a short time. Ether, if possible, is the best anæsthetic, being least depressing, or rather most stimulating. Brandy and opium (in form of I.M.H.) should be given while still unconscious if it be deemed necessary, and in most cases it will be.

The question as to what to apply after cleaning the wound is important. Vaseline mixed with boracic has been and is at the present time popular, because, unlike the usual animal and fatty substances, it is not readily absorbed by a raw wound surface, and a dressing of it, therefore, when requiring a change may, even after many hours, be peeled off a wound almost as when first applied, without the pain and bleeding which often accompany the removal of any other dressing. It has the disadvantages, however, that although itself mildly antiseptic it does not and cannot prevent the action of pyogenic or other germs not immediately in contact with it, and when it is remembered that the micro-organisms when present are not necessarily spread in a layer on the surface ready and waiting for the attacking antiseptic, its efficacy in cases not absolutely aseptic will be understood to be much modified. If discharge, serous or otherwise is present, and it usually will be for the first day or so, the layer of ointment will prevent the dressings from acting their part and soaking it up. Consequently frequent change of the dressings is required.

I need hardly mention that strong antiseptics are quite out of the question, as not only should they not be required if the primary cleansing has been thorough, but the possibility of their absorption by an extensive surface renders them extremely dangerous. The local damage to the tissues, too, which would result from their use, would probably increase the liability to a deep and deforming cicatrix.

Hazeline, the patent name for liquid extract of hamamelis, if applied so that the part is kept moist, is said to be a very good application. Its advantages are that it relieves the smarting pain, and one dressing can be left on for several days. It is, however, too expensive for hospital use, especially if used as freely as it should be.

I once tried sterilised gauze soaked in weak formalin on the scalded forearms of a big fish-porter. Although the wound did extremely well, still it was obvious when he came and asked me to change it at the end of the second day that it would not be feasible to use it in most cases. The smarting pain that it caused was such as only the least sensible could stand for any length of time.

Cocaine has been used to render the wound less sensitive, but the dangers of absorption and poison are too great to permit its use for any but the smallest wounds.

The most satisfactory application for clean burns and scalds is undoubtedly an alcoholic solution of picric acid. This has been known and used for many years by Professor Thiery, in France. It was Mr. D'Arcy Power who was the first to call attention to its merits in England. He described its method of use in the *Lancet* in 1896. The solution is made up by dissolving ʒiss. of picric acid in ʒiij. of alcohol, and adding two pints of water. This is practically a saturated watery solution of picric acid. The burnt area is thoroughly cleaned and the blisters pricked. Sterilized gauze is then soaked in the solution and the whole surface covered. Outside this plenty of antiseptic wool is bandaged on. Now, the advantages of using picric acid are these:—

1. The solution is a fairly powerful analgesic—boracic ointment has merely a passive action—preventing friction of the wounded surface. Picric acid decidedly diminishes the intensity of the pain.

2. It coagulates the albuminous exudation and leads to the early keratinization of the superficial cells of the granulations. This must to some extent limit the tendency to suppuration. It will thus be understood that the use of picric acid is indicated only when the recently injured surface has been rendered as clean as possible. With regard to this, however, I remember once, when I was assistant surgeon's dresser, applying picric acid solution to an old suppurating burn in a little girl, which had for weeks been insufficiently treated with boracic ointment and carbolic oil. Contrary to all theory, in four days' time, during which I did not renew the dressing, the wound had made such remarkably rapid progress towards healing, that the assistant surgeon under whom I was working was pleased to call the attention of his whole class to the case. But such a result is exceptional.

3. It allows of the absorption of serous exudation, which is always present for the first few days after the injury. This can pass through the gauze and be soaked up by the outer dressing. Consequently, a most important advantage accrues—namely, that the dressing does not require frequent renewal. If the wound is not deep, the first dressing can be left on often as long as four days, and the second one for a week.

4. The resulting cicatrix is smooth and supple, and to quote Mr. D'Arcy Power's words, "is as superior to the old burn scar as is the present primary union one to its predecessors."

These are the chief advantages. Minor ones are that it seems to be quite non-poisonous, or if it is poisonous is not absorbed by the injured surface. At any rate, no case has yet been recorded in which any ill effects arising from its use occurred. It is also cheap if not used too frequently, and the dressing changed unnecessarily. Its chief disadvantage is that it stains the fingers and the clothes. For the latter, the remedy is to apply plenty of wool outside the gauze. If the dresser finds it disadvantageous to stain the tips of his fingers yellow, a little boracic ointment smeared over them will, though at the sacrifice of absolute asepsis, prevent the disfigurements. Sterilized pads may of course be substituted if preferred for the gauze alone. Iodoform gauze has been used and found to be equally effective.

For the subsequent dressings the same precautions as regards cleanliness should be taken. It has been urged against picric acid that the dressing is very liable to stick to the wound. This disadvantage is merely a nominal one, gentle bathing with picric solution or boracic lotion will, with the exercise of a little care, easily obviate the difficulty. If the discharge, in spite of the initial cleansing, does become purulent—and in spite of all that can be done, this will be found frequently to occur—recourse must be had for a few days to hot fomentations, picric solution being subsequently again used when the granulations become more healthy. I do not propose to enter into the discussion of the various methods of skin grafting, treatment of contracting scars, and resulting deformities; the principles on which they are based are now well understood, and that branch somewhat remote from the main subject.

This, then, is the treatment suggested. It is not claimed for it that it will very materially shorten the tedious period of convalescence from this form of injury, although in all probability a few days will in most cases be gained. In the six cases I have referred to, in which an anæsthetic was used and picric acid applied, the average stay in the hospital was as much as thirty days. This is longer than the average given previously for cases of burns. But all cases—those dying within forty-eight hours or so—were included in that computation, and all these six cases were severe ones, two of them extremely so, and there is quite the possibility that if they had been less vigorously treated, they would have helped to swell the long list of rapidly fatal cases, and in so doing, have helped to reduce the general average length of stay in the hospital.

In conclusion, may I express the hope that I have not bored my audience with this somewhat lengthy paper. It has always been found a difficulty, in a paper such as this, to avoid giving excessive and irritating details, and it is a difficulty which, I fear, I have quite failed to surmount. But if anything I have said leads directly or indirectly to an improvement, however slight, in our treatment of these difficult, dangerous, and, to the dresser, usually tiresome class of case, then the time will not have been entirely wasted.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Reredos in the Chapel.—A Reply.

SIR,—The letter of "An Old Guy's Man," in your last issue, will have served a good purpose if it reminds others, as it has reminded me, to send in their contributions to the decoration of the chapel. The texts quoted by your correspondent scarcely form a sound argument against the adorning of churches. I suppose they were just as applicable at the time of the building of Solomon's Temple as now.

It is surely impertinence to presume that people who spend their money, like the Jews of old, on building and adorning the house of God are therefore less "spiritual" in their worship than those who save their cash or spend it on themselves.

It has yet to be demonstrated that persons who give to the beautifying of churches are close-fisted when asked to subscribe to charities. It is generally understood to be otherwise.

To my mind, a hospital chapel should be as beautiful as money can make it. Many of the patients in a London hospital rarely have their eyes gladdened with the sight of anything of beauty in all their dull and sordid lives, and when in the hospital they see the ward beautiful with flowers and pictures, it would come as a painful surprise to find the chapel dull and bare, and might, very naturally, make them conclude we thought very little of our worship and a good deal of our personal surroundings.

By-the-bye, would "An Old Guy's Man" suggest that nobody should buy flowers and send them to the hospital, and that all pictures and other decorations should be sold, and the proceeds invested in "real needs"?

"An Old Guy's Man" seems rather an expert in texts. I would advise him to read the story of a certain "alabaster box of very precious ointment," and digest the moral.

I enclose a postal order, which I will ask you to kindly forward to the proper quarter for me. This is the most effectual reply to your correspondent's letter. Apologising for troubling you,—I am, sir, yours faithfully,

ANOTHER OLD GUY'S MAN.

April 28th.

Nursing News.

It is with much regret that we have to announce, that owing to the death of her mother, Miss Anson (Sister Job), has been obliged to send in her resignation after eleven years' service.

We are pleased to be able to announce that Miss Grundy (Sister Beardoe), has quite recovered from her recent illness, and is able to take up her duties again in the Surgery.

It is with great pleasure we announce that Mrs. Price, who was here for seven years, has been elected out of a number of candidates, to the post of Matron at the Brompton Hospital for Consumption.

We are pleased to be able to announce that Miss Florence Chambers, who was trained here for three years, and afterwards worked in the India Army Servise, has been appointed Matron of St. Leonard's Hospital, Shoreditch.

We were delighted to welcome back Nurses Clarke, Nutt, and Powell, who went out with Major Lugard's expedition last year, to the West Coast of Africa. Nurse Nutt has promised to return again, and Nurse Powell will probably take Nurses' holidays here during the summer. Nurse Clarke's plans are, as yet, quite indefinite.

Nurses R. Garnet, E. Davies, and J. Gray, after having completed their three years' training, have been appointed staff nurses in their respective wards.

We are exceedingly grateful to the Students' Lawn Tennis Club for having offered the use of their Tennis Courts to the Nurses, every morning with the exception of Saturdays, instead of as in former years, twice a week. The Matron has in the name of the Nurses accepted this most kind offer.

The House Committee at their last meeting recommended to the Court of Committees that they should be allowed to spend a sum of £1,500 in levelling, fencing, and laying out the ground lately acquired at Honor Oak Park, and to build upon it a Club-house for the Nurses' Recreation Society. They further recommended that they should have power to appoint an advisory committee to assist them in settling plans, etc., and in drawing up a scheme for the management of the Recreation Society. The advisory committee consists of the Treasurer, the Superintendent, the Matron, the Assistant Matron, Mr. Harvey, Mr. Lafone, Dr. and Mrs. Shaw, Sisters Philip and Bright, Miss Iles and Nurse Willes. It is hoped that the first meeting of the Committee will take place next week.

In Lighter Vein.

The Superintendent recently received a letter concerning the admission into Bright of a patient "suffering from ephemeral hernia." This sounds hopeful enough to be trussed.

I apologise. That shall not occur again.

The following is a cutting from "The Queen's Service," a new book by Horace Wyndham.

Concerning the customary morning visit round the wards of a medico with a *penchant* for long words, there is extant rather a good story. He was accompanied on the tour by a General who was at the time making his annual inspection. This officer was of an inquiring disposition and demanded at every bed the particulars of the disease of its occupant. These were given him by the doctor in the most verbosely medical terms. Presently he was asked what was the matter with a certain consumptive patient.

"Phthisis, sir," he was told.

"Phthisis! I never heard of it. What is it?"

"Commonly called consumption, sir," was the reply.

"Why the deuce don't you speak English then, without any of your dashed medical tomfoolery about it? Phthisis, indeed!" snorted the General testily.

Shortly after he inquired in another ward, "What's the matter here? In English this time."

"Booze."

Last week I dropped in to an anti-vivisectionist meeting at St. James' Hall, and found Professor Lawson Tait addressing a crowded, but somewhat somnolent gathering. The Professor spoke in an impressive whisper, which no doubt carried great weight with the first row of stalls, but was quite inaudible from my seat; and this in spite of many requests not to mumble. Apparently he knew his own business best, for whenever his voice did reach the back of the hall he got rather badly scored off. Thus, when he announced, "Thank God I am no physiologist!" "No, and not much of a surgeon," cried the voice of the heckler.

Once, after a string of egotistical remarks from Mr. Tait, there was a cry of "Don't advertise." "I have no need to now," was the reply, and that time the Professor rather scored,

but for my part I thought the absence of necessity rather aggravated the offence. "In my younger days I have performed experiments in vivisection, but not one of them was successful," said Mr. Tait. "No, they take a little skill," came from the back of the hall, but this time the speaker was conveniently deaf.

There was an old lady in front of me who told me I had a cruel face, and who cried "Shame" when one of the speakers said that in vivisection experiments there were conditions which vitiated results. When the Bishop of Nottingham said, "Many people claim that animals have rights," she led a round of applause, but when he proceeded, "But we must guard against fallacious arguments; animals have not such rights," she was equally pleased and led another round. I fancy, however, some of the more enlightened brethren were not altogether pleased with the Bishop for giving away the "moral" argument.

But on the whole it was a dull affair, and the only really humorous circumstance was the presence of Mr. Lawson Tait on the same platform as a Bishop.

A deaf patient was requested the other day to write down an account of his symptoms, and this is what he wrote :—

"Honourable Esteem Gentlemens—I beg to acknowledge Its very unpleasant for Rich and Poor to be Disturbed In your Mind Because I am so very Deaf Not Able to Coverse with any Gentleman In any Troubles In Consequence of so great a Misfortune you will Please Excuse me in Troubling you valuable Time In Laying my Case before your kind Consideration This Last 5 Years I have Been so Distressed in my body I wont a Stick to rest upon To keep myself Upright If I Carry a Weight In Front of my Arms i feal I must Fall With it To the ground Its right in the Nable Its like a Tight Drawing in the Body I live as Well as any could Wish great Thick Slices of Food To give grater Strength All that i eat & Drink does not seem to Norish this Part of my Body Whotever So Weak Lifting any weight quite Overcome No pain Sir Eat & Dring at any time Never disturbes the Chest Its just Like a tight Drawing Causets very great Stooping Down the Loss of Strength with it There seems to be very Slight support this Part of my Body i have Mentioned to you Sir very much for the wont to Fill that Part of my Body out so Weak so Efficient Causes Effect I am quite surprised I am not more Fuller & satisfied than whot i am & my body Fealing so Strange & Distressed as it Does considering my Good Appatite I Eat enough To make myself Stout Its all the Reverse My kind Wife suggest I am getting old 63 years why should i Dispare wile these Experienced Influences Gentlemens Knowledge Freely Bestown To our kind People To the grater Comforts of Happiness To good Health and Strength Gentlemen I Appeal To your kindness for Two Weeks Medicine as i have Doble Fare to Pay a Friend To Guide me keep me Protected from Danger as i so Seriously afflicted with Deafness—Remaining Yours Humble Servant."

There is a note of pathos in that. The poor fellow has diabetes.

I trust nobody will put themselves to the trouble of writing to explain that the writer of the above was uneducated, and that's why his spelling is incorrect.

Appointments.

CIVIL.

Eyre, J. W. H., M.D., M.S. Durh., D.P.H. Camb., has been appointed Bacteriologist to the Charing Cross Hospital, London, and Lecturer on Bacteriology in the Medical School.

Harris, J. W., L.R.C.P. Lond., M.R.C.S., has been re-appointed Medical Officer for Frittenden.

Jordan, H. Martyn, F.R.C.S. Eng., has been appointed Registrar to the Chelsea Hospital for Women.

Parry, L. A., M.D., B.S. Lond., F.R.C.S. Eng., has been appointed Honorary Anæsthetist to the North West London Hospital.

Mr. H. L. Benson, L.R.C.P. Lond., of Market Deeping, has been appointed a Magistrate for the Kesteven Division of Lincolnshire.

NAVAL AND MILITARY.

Staff-Surgeon Edward H. Williams, is appointed to the *Impregnable*, Staff-Surgeon William W. Pryn to the *Champion*, and Surgeon F. C. Stearn, to the *Royal Sovereign*.

Captain E. M. Pilcher, R.A.M.C., is posted to Woolwich.

Captains W. H. W. Elliott, M.B., C. H. L. Meyer, M.D., and L. F. Childe, M.B., Indian Medical Service, are promoted to be Majors.

Lieutenant R. E. G. Phillips, R.A.M.C. is posted to the 1st Life Guards.

Birth.

STEWART.—On April 30th, at Walton House, Lordship Lane, S.E., the wife of H. M. Stewart, M.A., M.D. Cantab, of a son.

Marriage.

WORTHINGTON—LOWNDES.—On April 20th, at St. Andrew's Parish Church, Enfield, Sidney Worthington, M.D. Lond., F.R.C.S. Eng., of Chesterfield, to Alice Livingston Lowndes, granddaughter of the late Joseph Withers of Burleigh House, Enfield.

Deaths.

PRINCE.—On April 22nd, at Crowborough, Sussex, Charles Leeson Prince, M.R.C.S., F.R.A.S., aged 77 years.

SAVAGE.—On April 14th, at Winchelsea, Mary, the wife of Dr. G. H. Savage, of pneumonia.

Ed.—H. L. E.

Contents.

	PAGE
TWO CASES OF CEREBRAL CORTICAL LESIONS: Clinical Lecture by Dr. Newton Pitt...	201-207
HOSPITAL NEWS	207-209
THE TREASURER'S REPORT FOR 1898...	209-210
CHAPEL NEWS	210
GUY'S HOSPITAL CHRISTIAN UNION	210
THE HOSPITAL FOR SICK CHILDREN: Notice	210
PASSIM	211-212
GUY'S HOSPITAL DENTAL SOCIETY	212-216
IN LIGHTER VEIN	216-217
CHAPEL NEWS	217-218
PASS LIST	218
SPORT: Cricket—List of Matches: First Eleven; Guy's v. Waldegrave Park; Guy's v. Hornsey; Guy's v. Crystal Palace; Guy's Hospital Lawn Tennis Club—List of Matches: First Six, Second Six; The Competitions; Guy's v. Boundaries	219-220

Calendar of Coming Events.

May, 1899.

Sat. 18.—Messrs. Lucas and Lane's take-in; Drs., H. B. Foster and J. Atkins; Cl., F. D. Turner.

Sat. 20.—Cambridge 1st and 2nd M.B. Exams. Schedules to be brought to the Medical School Office for signature.
G.H.C.C., I., Surbiton, 11.30 a.m., away.
II., Thornton Heath, 2.30 p.m., home.
G.H.L.T.C., Blackheath, away.
Hos.-Scho. C.C., Courage & Co., home.

Mon. 22.—Whit Monday, Medical Office closed.
G.H.C.C., I., Eltham, 11 a.m., home.
Hos.-Scho. C.C., Great Northern Hospital, home.

Tues. 23.—G.H.S.C., Rana, away.

Wed. 24.—Final Fellowship Exam.
1 p.m., Clinical lecture by Dr. Shaw.
G.H.C.C., II., London Hospital, 2.30 p.m., away.

Thur. 25.—Messrs. Golding-Bird and Dunn's take-in; Drs., G. Lewin and R. D. Attwood; Cl., J. G. Taylor.
G.H.M.P.U., Special Meeting.

Fri. 26.—1 p.m., Clinical lecture by Mr. Symonds.

Sat. 27.—G.H.C.C., I., Beckenham, 11 a.m., away.
II., Dulwich, 2.30 p.m., home.
G.H.B.C., Run to Maidenhead.
G.H.L.T.C., Kent L.T.C., home.
Hos.-Scho. C.C., Wandsworth Prison Officers, away.

Tues. 30.—G.H.S.C., Rana, home.

Wed. 31.—1 p.m., Clinical lecture by Dr. Shaw.

June.

Thur. 1.—Messrs. Howse and Jacobson's take-in; Drs. A. C. Lewis and T. T. Kelly; Cl., J. T. Dunston.
July Appointment List opened.
G.H.M.P.U., Address by Rev. F. B. Meyer.

Fri. 2.—1 p.m., Clinical lecture by Mr. Symonds.
Last day for names to be sent in for first and second M.B. Camb. exams.

Sat. 3.—Last day for applying to Registrar for Form of Entry for Intermediate M.B. Lond. Exam.
G.H.C.C., I., Reigate Priory, 11 a.m., away.
II., St. Bart's., 2.30 p.m., away.
G.H.B.C., Run to Maidenhead. Meet at Elephant and Castle.
G.H.L.T.C., Harold, away.
Hos.-Scho. C.C., Corpus Christi, home.

Guy's Hospital Gazette,

MAY 20, 1899.

Two Cases of Cerebral Cortical Lesions.

CLINICAL LECTURE BY DR. G. NEWTON PITT.
February 4th, 1899.

GENTLEMEN,—We have at the present time two cases in the wards of what appear to be Cortical Lesions of the Brain, and although we cannot in either be quite certain as to the nature of the lesion, still they present very interesting points for discussion, and will form a good subject for consideration to-day.

CASE I.—RECURRENT EPILEPTIFORM ATTACKS, FOLLOWED BY APHASIA, WHICH PERSISTED. GANGRENE OF LUNG. PARTIAL RECOVERY.

The patient is a railway porter, æt. 36, who came into the hospital at the end of December (Clinical Clerk, Mr. W. H. Telling). About a year ago he had a fit, and since then he has had others, and as far as we can judge the fits seem to have been throughout very much of the same nature. Shortly after the first fit he fell and cut his head, but can give no sufficient reason for his falling. Possibly he had had another fit. Since then he has had fits at intervals of every month or six weeks, occasionally having two or three consecutively. The fits cannot be differentiated from ordinary attacks of epilepsy. They are not preceded by any definite aura; but it has been noticed that there is generally a noise in his throat; he becomes unconscious and rigid, and this is followed by clonic movements; he bites his tongue and has no recollection afterwards of the attack. He frequently vomits as he comes to, generally an hour after an attack. He is very often laid up for two or three days afterwards.

He was found on the 22nd of December, lying insensible on the ground with an injury to his head; when admitted he was in an

incoherent, violent, noisy condition, and apparently had taken a considerable amount of alcohol. During the night he had several more fits, which were shortened when he inhaled amyl nitrite. There was an incised wound in the right occipital region, but no evidence of any injury to the brain. During the night his pulse and respiration became feeble and he was in a very critical condition; it seemed doubtful whether he would survive. However, this crisis gradually passed off. The next day he had a fit and became so noisy and violent that it was found necessary to remove him to the strong room.

When he first came in, his temperature was 101·4°, and remained slightly raised for a day or two, but became normal at the end of the third day. The pulse was 120. It was quite impossible to obtain any information from the patient; he could not understand what was said to him, and his replies were quite incoherent. It shortly became obvious that he had undoubtedly well-marked aphasia of a sensory type. At first there was a slight trace of albumen in the urine, but that soon cleared off. His knee-jerks were normal. He continued to gradually improve for some time, but remained in a state, more or less of stupor, with great defect in his speech. He was unable to read when given a book, he simply read gibberish. No paralysis.

After some days he came down to the ward again, but was so disgusting in his habits, and so noisy and incoherent, that it was necessary to transfer him again to the strong-room. On the 7th of January he had incontinence, and passed into a state of almost complete stupor. It was noticed that his temperature was always raised a degree or two (as was shown by the chart), running up now and again to 104°, but varying for the most part between 100° and 102°, and it became clear after the first or second week in January that he had also some septic pneumonia, involving the lower and posterior portion of the right lung. I have no doubt this was due to aspiration of food into the lung during his stupor. On examining the lungs there were found, defective movement, numerous consonating râles, and evidence of mischief at the angle of the right scapula. So long as the patient remained on his right side he was comfortable, but if he turned over to the left he was at once seized with a violent fit of coughing, and his breath became excessively foul, these symptoms being evidently due to an acute necrotic condition of the lung. Some of the gangrenous foul fluid material was enabled, when the patient was turned to the left, to gravitate into the bronchi. Up to the present time his condition has greatly improved, but even now when he is turned on the left side, his breath at once becomes extremely foul, and he has violent paroxysmal attacks of cough. This is a mere incidental complication to his condition, and probably has arisen since he has been in the hospital.

At the present time, February 4th, his mental condition has greatly improved; he has had no fits for some time past, but still has well-marked aphasia. A short time ago he did not know his own name, where he lived, nor could he name any objects. But he is able now to name the majority of objects fairly satisfactorily. When he reads, the words he pronounces are quite different from those in the book. Very often they are mere gibberish, but at the same time he understands the greater part of what he reads. He is rather deaf, which perhaps adds to his difficulties, but he is each day, I think, improving in his speech; though every now and then it is quite clear he but imperfectly understands what is said to him. There is no evidence of syphilis. The heart, the pupils and the optic discs are normal.

About the middle of last month I asked Dr. Savage to see him, and he agreed with me that although the man was noisy and mentally very feeble, his mental feebleness was more apparent than real, being due to his aphasia, and that the lesion was probably a gross one, rather than a diffused degenerative condition such as causes general paralysis. The patient was at first put upon bromide of potassium and a small dose of iodide of potassium, but at the beginning of January the dose of iodide of potassium was increased to 20 grains, which was taken regularly three times a day with a tumbler of water and some aromatic spirits of ammonia.

Owing to his extremely defective appetite and his feeble condition, on January 11th we decided to stop the iodide of potassium, and there is no doubt that after the iodide was stopped his appetite improved, and generally his condition was very much better. Still, it was wise to give him the iodide of potassium, and he has benefited by it. For the extreme foulness of breath and gangrenous condition of the lung we have been giving him creasote. He began with one minim of creasote four times a day, and he is now taking five minims of creasote five times a day; the condition of his breath has very much improved, only being foul when paroxysms of coughing come on. For the last few days, as he is getting more sensible, he has been ordered a spray of 1 per cent. formalin in a globe

nebuliser for him to inhale into the deeper portions of the bronchi, with a view to getting the breath less foul.

There is but little question that he has a gross lesion. The man has been in the hospital five weeks with persistent definite aphasia. It is extremely difficult, and very often, impossible, during the acute stage, to make up your mind to what extent such a condition as aphasia or paralysis may be temporary or permanent, but when four or five weeks have passed and you still have paralysis or aphasia, you almost certainly have some gross lesion. It is also, I think, clear that the lesion is in the cortex, and the fact that his speech is defective in certain particulars only—he now pronounces his words normally—indicates that there is no severe lesion of the motor function of speech, but rather a defect in some process of storage of words and of the associated ideas which he has acquired through his eyes and ears. The associated ideas connected with speech, and with images for the eye, are stored up in the angular and supra-marginal region on the left side of the brain; and the associated ideas in connection with things that are heard are stored up in the first temporo-sphenoidal convolutions on the left side. I do not know that at present we can sufficiently make up our minds that only one of these regions is involved. It is most probable there is some partial involvement of both these areas, as he is unable to write voluntarily or from dictation, name objects or repeat a sentence without making mistakes. He writes better by copying than from dictation.

It is difficult to speak with any certainty as to the nature of the lesion. Most probably it is a syphilitic pachymeningitis. I have a specimen here of a brain from another patient who had curious convulsive attacks, which seemed to be largely under his control, and were looked upon as being probably hysterical. But he had some slight optic atrophy following on neuritis, together with hemiopia. Therefore I felt certain it was not a case simply of hysteria. I kept my eye on the man's whereabouts, and some two years afterwards, when he died, Dr. Cuff sent me his brain from Scarborough. You will see here a very extensive syphilitic pachymeningitis involving a large area on the left side of the brain. There is gummatous material between the meninges, which has also infiltrated the cortex in some parts. I have no doubt the convulsive attacks arose from the infiltration of the cortex by the gummatous material, and the hemiopia from the damage done to the supramarginal and occipital convolutions.

Case II.—Recurrent Right-sided Epileptiform Attacks with Right Hemiplegia.

The patient is a man, æt. 49, who came into the hospital on the 1st of February (Clinical Clerk, Mr. T. P. Berry). The history is, that he was quite healthy until the summer of 1897, when he complained of the heat and had some mental disturbance. He did stupid things which he had not been previously in the habit of doing, and was somewhat queer in his manner. This, however, passed off, and he was practically himself again until September, 1898. One morning he was noticed by his wife to put his hand up to the right side of his head, and to sit up in bed in a dazed sort of way; he refused to answer when she asked what was the matter. A little later his wife found him standing by the wash-stand, and again she could not get any reply from him. Evidently there was some mental disturbance. On returning to his bed, his left hand was noticed to shake, and he was convulsed, the convulsions continuing until the afternoon, when they passed off. He did not become fully conscious until two days later. He gradually recovered, and returned to his work after five or six weeks. It was noticed that his speech was very incoherent for a day or two at the time of his attack. He remained all right until December, two months later, when he one day was found on board ship in a fit. When his wife saw him shortly afterwards, he was unable to speak to her. He knew what he wanted, but was unable to ask for it, and he had lost power in the right arm. He was admitted under Dr. Washbourn with aphasia and weakness in the right arm and leg. His symptoms improved, but later he became worse, the aphasia increasing for a time. A few days later his speech was normal, and it was noted he was very jovial and had ideas of grandeur, but this has not been noticed since then. He went out within ten days of admission. Since then nothing special had been noticed with regard to the patient until the afternoon of February 1st. At four o'clock he fell down and had a series of right-sided fits, which continued on and off until the next afternoon. At first they were very frequent, and varied much in intensity. During the early morning of the 2nd they became much less severe, but for twelve hours they were almost unceasing; he was quite unconscious; he passed his motions under him, and had incontinence of urine.

The description of the attacks is as follows: They were almost all of them right-sided, and

commenced by twitching in the muscles of the face, the head being drawn to the right, with deviation of eyes to the same side. The muscles of the arms were involved, the fingers being affected before the wrist. Then the leg became affected, and the right side of the body became rigid. After a minute or more the attack quieted down, to be succeeded by another after a short interval. But apparently a few of the attacks differed from those which I have described. In some severe convulsions started on the right side, spread over to the left, and became universal. One or two of the attacks, it was thought, did not commence in the right side, but in the left. After the attacks, the right arm and leg were found to be paralysed. The right knee-jerk was absent. There was an insensitive conjunctiva on the right side, while the conjunctiva on the left was sensitive; but this seems to have varied somewhat. There was no optic neuritis. The urine was free from albumen: there was retention. The patient had a drachm of bromide of potassium given him soon after admission. At nine o'clock at night he was bled; at eleven, chloroform was administered, but soon afterwards the fits returned. At midnight he had an injection of 2 drachms of syrup of chloral, and 20 minims of tincture of belladonna per rectum, which was repeated. I may point out that for a condition of status epilepticus, the most useful drug is chloral; it is to be given in doses of 20 grains, repeated as necessary, by mouth or per rectum.

The rapid recurrence of fits, one after another, is quite sufficient to produce hyper-pyrexia and death: so that it is absolutely necessary to bring them to a conclusion as soon as you can. Sometimes you find chloroform satisfactory, but in this case the anæsthetic did not seem to benefit the patient. "The patient has remained in a state of stupor since he was admitted. He had four or five slight fits on February 3rd, and some four fits during the past night, quite slight compared to those previously, but commencing in the same way, in the face, and spreading down to the arm."

Well, now the question is, What is the nature and site of the lesion? It is probably a cortical one, on account of the localized convulsive attacks. When we come to discuss the nature of the lesion it undoubtedly remains obscure. I want to draw your attention to the temperature chart. The temperature taken every hour shows, as you will see, that it was 99·8° at midnight and gradually rose to 102°, the temperature in the right axilla being a degree higher than that in the left, and this difference of 1° to 1·5° has persisted. This is very frequently the case with hemiplegia. You will notice that it depends very much on the extent to which the limbs are covered. If the limbs are kept covered in an acute attack of hemiplegia, the paralysed limbs will have a higher temperature than the other side. But if the limbs are exposed to a cold atmosphere, the temperature on the paralysed side is lower than that on the other. This difference of temperature is largely due to vaso-motor paralysis of the vessels in the affected limb.

To discuss some of the lesions which may produce these symptoms. Referring to the more common cortical lesions which might produce such attacks, first of all, by far the most common and important is—

(1). *Softening.*—This may arise in connection with embolism from heart disease, or with thrombosis due to syphilitic or to atheromatous changes in the blood vessels.

(2). *Hæmorrhage.*—Many of the degenerative arterial changes which lead to hæmorrhage in the interior of the brain may also lead to hæmorrhage on the surface, but undoubtedly hæmorrhage on the surface of the brain is more infrequent than in the neighbourhood of the external capsule of the brain.

(3). *Pachymeningitis.*—This may be due to syphilis, as in the case referred to above. It may also spread through from some external disease of the bone, or external injury.

(4). *Hæmorrhagic sub-dural cysts* are formed by the organization of blood which has been extravasated on the surface of the brain, and may give rise to irritation. These are often described as due to pachymeningitis, but they are not inflammatory in origin, but are simply organising capsules due to extravasation of blood on the surface of the brain.

(5). *Cerebral tumours.*

Then comes an important group to which I wish especially to refer, namely:

(6). *General paralysis of the insane, insular sclerosis and tabes.*—In these diseases you may meet with apoplectiform or epileptiform attacks which are transitory in their nature, and are associated with a considerable rise of temperature. They very often give rise to great difficulties in the question of diagnosis if you do not bear them in mind. They are not common, but any of the three may be associated with convulsive attacks.

(7). *Epilepsy.* (8). *Hysteria.* (9). *Uræmia.*—Some of the various causes I have mentioned are much more important than others.

First of all, to say something with regard to softening. Usually a differential diagnosis may be made between those cases due to embolism, and those which are due to syphilis and to degenerative arterial changes. Embolism occurs generally in young people, very often in children; as a rule the onset of symptoms is sudden, but not necessarily so. Some cases of embolism undoubtedly occur in which the onset is not sudden. This is best shown by the cases of cerebral aneurysm due to infective endocarditis and embolism, where the first thing noticeable has been the rupture of the aneurysm, and there has been no indication of any cerebral lesion during the time the aneurysm was forming.

The cases of syphilis occur usually under forty years of age, more often in men than women, and are generally preceded by headache. They occur within the first four or five years after the infection, and are not, as a rule, a late syphilitic process. Generally there are also other evidences of syphilis. The cases due to atheroma of the vessels are almost invariably in elderly people. Between the ages of forty and sixty-five, cerebral hæmorrhage is far more common than softening; before the age of forty and after the age of seventy, softening is the more common cause of hemiplegia. So that from forty to sixty-five a hemiplegic condition is more probably due to hæmorrhage; before and beyond these ages it is more commonly due to softening.

You may divide the symptoms which develop at the onset of softening, into two groups: those in which the onset is acute, and those in which it is gradual.

(*a*). *Acute.*—The paralysis will sometimes involve the whole of one side without any loss of consciousness ensuing. That is a very important point of differentiation. In hæmorrhage, on the other hand, it is not common to find total paralysis of one side, without loss of consciousness at the onset. Jacksonian epilepsy is more common with softening, the convulsive attacks commencing in one or two muscles, and often are limited to certain groups, without becoming universal. The attacks vary from localised twitchings to generalised convulsions, but there are generally intervals of consciousness between the attacks of convulsions: on comparing the symptoms with those which occur in connection with cerebral hæmorrhage, the coma is far less intense, the tendency to convulsion is far greater, and the pulse rate is not below normal. In cases where the softening is due to thrombosis following on atheroma, the pulse is often feeble. The temperature is also very important.

The effect of a cerebral hæmorrhage is generally to produce a sudden fall of temperature, which remains below normal, if the patient dies within a few hours and does not recover from the collapse. As the collapse passes off the temperature runs up to 101° perhaps, remaining at that for two or three days; if the lesion is then proving fatal, the temperature may run up above 106° before death, but if the patient survives, the temperature at the end of a week comes down to normal. The temperature, therefore, is very important both with regard to prognosis and also to diagnosis, because in cerebral softening there is not this well-marked drop in the temperature at the onset, but the temperature very quickly begins to rise, and the rise which occurs at the end of forty-eight hours is, as a rule, considerably higher than that which occurs in hæmorrhage, amounting to 102°. An early rise of temperature is, therefore, in favour of softening as against hæmorrhage. The temperature is raised in the spinal lesions mentioned, but it is not in epilepsy unless a status epilepticus develop.

In softening, the paralysis often tends to progress. After the acute attack is passed, further thrombosis may take place in the vessels, and further paralysis ensue. Still a hæmorrhage also may recur. Thus, though not an absolutely distinctive point, the paralysis more frequently progresses in cases of softening than of hæmorrhage.

(*b*). In some the onset is *gradual*: preceding the attack for some days there has been numness and tingling, and very often painful sensations in the limbs which are ill-defined until the attack has occurred. These sensations occur particularly in connection with the upper extremity. In many cases, some twenty-four or forty-eight hours before the limb is absolutely paralysed, the patient complains that it is becoming heavy and clumsy, and it gradually becomes more or less useless until the paralysis becomes quite obvious. In cases of softening, aphasia is much more common than in cerebral hæmorrhage.

As to sensation. It is often said that there is no sensory disturbance present in cases of cerebral softening. Doubtless it is often difficult to make out, but there is certainly much more sensory trouble in cortical lesions than there is in those which are deep-seated. With cortical softening there is always considerable defect in tactile sensation and very marked loss of muscle sense. On the other hand, where softening is deep-seated you may have no sensory disturbance. The only deep-seated cases of softening

in which you are likely to find sensory disturbance are some of those in which the optic thalamus is affected, particularly in connection with syphilis.

Death in the early stage of an attack due to softening is infinitely rarer than in cerebral hæmorrhage. In cerebral hæmorrhage a large number of patients will die within three or four days, whereas, in softening, death, if it occur, is much later.

Associated symptoms are often of value in determining the diagnosis. In ordinary hemiplegia, as soon as the patient recovers from the coma, however severe the paralysis, you never have any defect in swallowing. When, in hemiplegia, you have a defect in swallowing, you may feel pretty certain there has been some previous lesion on the other side of the brain. Quite a small lesion in the anterior part of the internal capsule, or in the frontal lobe, may be sufficient to produce complete inability to swallow if there is also an old lesion on the opposite side. We had a man in the hospital who had one small patch of softening involving the internal capsule on one side, and a rather larger one on the other, and he was absolutely unable to swallow, and had to be fed for weeks with a nasal tube, he was also unable to articulate. Glosso-labio-laryngeal paralysis in a hemiplegic attack is suggestive of a previous lesion on the other side of the brain; this is more common in softening than in hæmorrhage; it may occur in either.

But, neither in the mode of onset, nor in the symptoms, nor in any single feature can you be absolutely certain of distinction between the two—it is rather by the discussion and consideration of a number of points. Recurrent convulsions are rarely due to cerebral hæmorrhage, because the lesion is in the deeper portion of the brain. Still, in the not inconsiderable number of cases in which the hæmorrhage occurs on the surface, convulsive attacks may develop. When it occurs on the surface, there is often hæmorrhage on both sides of the brain, and in such cases convulsive attacks occur not limited to one side, but involving both. So also when an internal hæmorrhage bursts into the lateral ventricles, convulsions may develop. But the most characteristic feature of a hæmorrhage rupturing into the ventricles is the occurrence of rigidity. If a left-sided hæmorrhage burst into the ventricle, the presence of the blood in the ventricle will produce rigidity of the left side. In a case of softening this is not so. An early rigidity in softening is excessively rare. In softening, if rigidity occur, it is generally after the lapse of two or three weeks, and it is of importance, because it gives you some idea as to which limbs will become permanently rigid and contracted. The reflexes at the end of two or three weeks will become exaggerated, the affected limbs will become rigid, and permanent contractures will gradually develop.

As to the tone of the muscles in connection with cerebral softening, I think, speaking roughly, you may say that where the tone of the muscle is preserved, the lesion is limited to the cortex; but when the lesion extends down to the capsule the tone of the muscles disappears.

In the present case, although the patient's right limb is quite paralysed, there is a certain amount of tone in the muscles, which is an indication that the capsule and the fibres away from the cortex have not been destroyed, and that the lesion is limited to the superficial portion of the cortex. When the fits are numerous, it is very strong evidence that the lesion is limited to the superficial portion of the cortex, and has not spread deeply down and destroyed the fibres below.

Aphasia is not an uncommon symptom with softening. By examining a patient thoroughly you will very often find some defect or other in speech when there is softening of the left cortex. And in some cases you may also find defects in the field of vision. Of course, the field of vision, which as you know is merely referred to the occipital cortex, is supplied by the posterior cerebral artery; whereas the area supplied by the middle cerebral must be affected to produce hemiplegia. Supposing, therefore, a patient has convulsive attacks with hemiopia (as in Dr. Cuff's case), it is quite clear you are not dealing with a case of softening, because the areas affected are supplied by different vessels. Convulsive attacks with hemiopia are pretty certainly due to some irritation of the cortex, such as syphilitic pachymeningitis, and not to embolism or thrombosis.

There are no evidences of either insular sclerosis or locomotor ataxia in this patient.

All we can say with regard to this man, is that we have probably a lesion of the cortex which apparently does not extend deep into the brain, and which has not interfered materially with the fibres in the capsule. But it is too early at present to say how much of the paralysis will be permanent. We must wait for another week, at least, before we can speak with any certainty, and until we are clear with regard to this we cannot absolutely exclude the

possibility of the changes in this patient being diffused degenerative changes in the meninges and cortex of the brain, such as you meet with in general paralysis. Should we find that this man, at the end of a month, has permanent aphasia, or permanent paralysis, then you may certainly say you have got a gross lesion, and not a diffused degenerative one.

Besides the lesions of softening, hæmorrhage and pachymeningitis, of course there is also the question of cerebral tumour, which is extremely improbable in this case. With a cerebral tumour you have headache and optic neuritis. The development of optic neuritis varies very much. In certain cerebral tumours it develops very early, whereas, in others you find a year or even more going on before the optic neuritis becomes obvious. In the case of pachymeningitis referred to it was a long time before there was any marked change in his discs. In another patient a tumour was developing more than a year before there was any optic neuritis visible.

The amount of headache varies, but as a rule cortical tumours are associated with headache early in the disease. In cases of tumour not involving the cortex, headache may not be such an early symptom.

The diagnosis appears to lie between softening, pachymeningitis, and general paralysis; the first being the most probable. We cannot absolutely exclude hæmorrhage, because at present the arm, the face, and leg are all involved. If the attacks were more definitely limited to either the face or the arm, then I think the probability of hæmorrhage would be very small. But I thought the case was worth discussing, although the diagnosis as to the actual lesion will probably remain uncertain.

Postscript.—After the delivery of this lecture the patient continued to have fits of no great severity, many being limited to his face or face and arm. He developed extensive septic broncho-pneumonia over the right lung, and died on February 5th. No gross lesion such as we had rather expected was found in the brain. The membranes were thickened and the convolutions wasted. It is clear, therefore, that the fits were due to general paralysis of the insane, and it is of interest to note that he had definite right hemiplegia for the four days he survived.

There had been slight ideas of grandeur for a few days in December, but these had not recurred.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Pye-Smith.

Philip	23.	Acute Bright.
	24.	Bronchitis simulating phthisis.
	25.	Mitral regurgitation. Tricuspid regurgitation.
	29.	Emphysema. Chronic Bright. Mitral regurgitation.
	35.	Ascites. Tuberculous peritonitis.
	37.	Severe headache, probably meningitis.
	38.	Malignant stricture of œsophagus.
	39.	Nephralgia. ? Calculus. ? Tuberculous disease.
	40.	Acute rheumatism. Presystolic murmur.
Mary	25, 33.	Exophthalmic goître.
	26.	Ascites. Multiple ovarian papillomata.
	28.	Diabetes mellitus.
	29.	Mitral regurgitation and stenosis.
	32, 36.	Acute nephritis.
	34.	Rheumatism, first attack. Mitral regurgitation. ? Infective endocarditis.
	37.	Hepatic colic. Gallstones.

Cases under Dr. Taylor.

Mary	38.	Neuritis.
	40.	Exophthalmic goître.
	42.	Carcinoma ventriculi.
	43.	Jaundice. ? Carcinoma hepatis.
	45.	? Pernicious anæmia.
	46.	Broncho-pneumonia.
	47.	? Tuberculous kidney.
	48.	? Gastric ulcer.
	49.	? Ulcerative colitis.
Stephen	1.	Old pleuritic effusion. Continued pyrexia.
	2.	Acute rheumatism. Aortic regurgitation
	3.	Post influenzal headache.
	4.	Pericarditis.
	5.	Pneumonia.
	7.	Empyema.
	8.	Intestinal obstruction. Operation.
	10.	Mediastinal growth.
	12.	Laryngeal obstruction.
	14.	Senile dementia.
	19.	Locomotor ataxy.
	20.	Phthisis.

Cases under Dr. Hale White.

Mary	13.	Abdominal tumour.
	15.	Peripheral neuritis.
	16.	Fibroid lung. Bronchiectasis. Displaced heart.

Mary	18.	Rheumatic fever.
	20.	? Gastric ulcer.
	22.	Cerebral tumour. Operation.
	24.	Mitral constriction and regurgitation. ? Aortic stenosis.
Philip	1.	Diabetes mellitus.
	2.	Gonorrhœal arthritis and ophthalmia.
	5.	*Transverse focal myelitis. Syphilitic.*
	7.	Optic atrophy. Cirrhosis.
	9.	Empyema. Operation May 12th.
	10.	Hodgkin's disease.
	11.	Chronic peritonitis.
	12.	Emphysema and bronchiectasis.
	14.	Chorea.
	17.	Ascites. ? Growth.
	18.	Rheumatic fever. Recurrent attack.
	19.	Cirrhosis.

Cases under Dr. Pitt.

Stephen	22.	Dermatitis herpetiforme. (Large increase in number of eosinophytes).
	23.	Diabetes mellitus.
	26.	Pericarditis. Rub. Systolic bruit at apex.
	30.	Recurrent pneumonia.
	31.	Growth in anterior wall of stomach.
	34.	Hodgkin's disease.
	40.	Epilepsy (minor).
Mary	6.	Cirrhosis of liver. Ascites.
	7.	Chorea insaniens.
Cot	51.	Diphtheria. Tracheotomy.
Cot	52.	Diphtheria. Tracheotomy.

"Clinical."

John	1.	Neuritis of pneumogastric. Tachycardia.
	2.	Pericarditis. Mitral stenosis and regurgitation. Jaundice.
	3.	General suppurative peritonitis. Operation.
	4.	Thoracic aneurysm.
	5.	Cerebellar tumour.
	7.	Appendicitis. Operation.
	12.	Focal hæmatomyelia. Lumbar.
	13.	Abdominal tumour. Malignant.
	15.	Appendicitis. Operation.
Miriam	17.	Adhesive endarteritis.
	18.	Empyema. Operation.
	21.	Marasmus. ? Meningitis.
	22.	Septic endocarditis. Renal emboli.
	25.	Typhoid. Acute pneumonia. Convalescent.
	31.	Progressive muscular atrophy.
	32.	Phthisis. Cavitation. Cardiac failure.
	33.	Meningitis. ? Tuberculous ulceration of the intestine

In the Surgical Wards.

Cases under Mr. Howse.

Naaman	1.	Strangulated femoral hernia.
	3.	Aural polypus.
	4.	Melanotic sarcoma of groin.
	5.	Hernia. Inguinal and omental.
	6.	Hydrocele.
	7.	Tuberculous hip.
	8.	Glands in neck. Tuberculous.
	10.	Undescended testicle.
	16.	Renal calculus.
	17.	Vesical calculus.
Dorcas	1.	Recurrent growth in scar after excision of breast. Œdema of arm.
	2.	Injury to hip.
	3.	Tuberculous glands in neck.
	4.	Hip-joint disease.
	6.	Strangulated femoral hernia.
	7.	Pes cavus. Localised gangrene.
	10.	Lupus of face.
	11.	Varicose veins.
	12.	Tubercular breasts. Right and left affected.
	13.	*Villous growth of bladder.*
Cot	A.	Nævus of face.

Cases under Mr. Davies-Colley.

Job	1.	Reducible inguinal hernia.
	3.	Mastoid disease.
	4.	Tubercular glands.
	7.	Osteitis of os calcis.
	8.	Fissure of anus.
	9.	Perineal abscess.
	10.	Fractured patella.
	11.	Epithelioma of buttock.
	21.	Varicose veins.
	23.	Double spermatocele.
	24.	Hammer toe.
Lydia	2.	Injury to arm.
	4.	Concussion.
	6.	Hydatid of liver.
	9.	Suppurating hæmatoma of neck.
	10.	Tubercular breast.
	12.	Carcinoma recti.
	14.	Fractured femur.
	16.	Excision of eye. Injury.
	17.	Carcinoma mammæ.

Cases under Mr. Lucas.

Lazarus	1.	Epithelioma of neck.
	4.	Appendicitis.
	5.	Tuberculous abscess.
	6.	Stricture of œsophagus.
	7.	Secondary glands. Epithelioma of face.
	9.	Varicocele.
	11.	Malunited fracture of tibia and fibula.
	12.	Excision of knee.
	18.	Genu valgum.

MARTHA	5.	Tuberculous elbow.
	7.	Cerebral abscess.
	8.	Fractured femur.
	9.	Carcinoma mammæ.
	16.	Cleft palate.
	17.	Tuberculous glands in axilla.
	19.	Dislocated ulna.
	20.	Carcinoma mammæ.
	21.	Perinephritic abscess.
	22.	Epithelioma of scalp.

CASES UNDER MR. GOLDING-BIRD.

LUKE	5.	Inguinal hernia.
	6.	Renal calculus.
	7.	Varicose veins.
	8.	Multiple papillomata of rectum.
	10.	Malignant growth of testicle.
	11.	Enlarged prostate.
	13.	Right inguinal colotomy. Colitis.
	14.	Epithelioma of lip.
CHARITY	2.	Ventral hernia.
	3.	Umbilical hernia.
	4.	Carcinoma mammæ.
	5.	Lipoma.
	6.	Tubercular ankle.
	8.	Fractured fibula.
	9.	Glands in neck.
	15.	Adenoma.
	16.	Fractured femur.
	17.	Recurrent appendicitis.
Cot A.		Talipes equino-varus.
Cot B.		Spinal caries.

CASES UNDER MR. JACOBSON.

NAAMAN	21.	Inguino-scrotal hernia.
	23.	Hip-joint affected after febrile attack. ? Septic arthritis.
DORCAS	21.	Hæmorrhoids.
	22.	Melanotic sarcoma.

CASES UNDER MR. SYMONDS.

JOB	13.	Injury to elbow-joint.
	14.	Hypochondriasis.
	19.	Recurrent glands. Epithelioma of tongue.
LYDIA	20.	Multiple adenomata of thyroid.
	21.	Tubercular knee.
Cot D.		Retro-pharyngeal abscess.

CASES UNDER MR. LANE.

LAZARUS	2.	Laryngeal stenosis. Tracheotomy.
	14.	Necrosis of skull.
	15.	Rodent ulcer.
MARTHA	10.	Ankylosed elbow.
	12.	Appendicitis.

CASES UNDER MR. DUNN.

LUKE	1.	Varicocele.
	3.	Appendical abscess.
	4.	Intestinal obstruction. ? Colic.
CHARITY	20.	Sinus in breast.
	23.	? Osteoma of upper jaw.

In the Eye Wards.

CASES UNDER MR. HIGGENS.

BARNABAS	3.	Injury to cornea. Prolapse of iris.
	4.	Interstitial keratitis.
	9.	Trachoma.
	10.	Glaucoma.
	13.	Choroiditis.
	18.	Senile cataract.
	23.	Optic neuritis.
RUTH	24.	Corneal ulcer.
	25.	Glaucoma.
	26.	Strumous keratitis.
	33.	Detached retina.

CASES UNDER MR. BRAILEY.

BARNABAS	14.	Iritis.
	17.	Sarcoma of orbit.
RUTH	31.	Cataract.
	32.	Glaucoma. Iridectomy.

The Treasurer's Report for 1898.

Mr. BONSOR'S Annual Report to Donors and Subscribers has just been issued, and gives account of the hospital up till the end of 1898. The year's progress has been quiet but steady, so that there is nothing of very striking interest to record.

The hospital has lost four governors during the year: Mr. Gladstone, Sir Thomas Dyke Ackland, Bart., Mr. Abel Smith, M.P., and Mr. Arthur Mills, while among those elected to the corporation are mentioned the names of the Rt. Hon. A. J. Balfour, M.P., Sir Samuel Wilks, the Rt. Hon. Earl of Pembroke and Montgomery, and Sir Frederick Wills, Bart.

The report shows everywhere increase in work and efficiency. In 1898, 6,701 patients were admitted into the hospital, being 92 in excess of the previous year, and the largest number yet recorded. The number of out-patients has also largely increased, 76,211 in 1898 as compared with 68,000 in 1897. This increase is principally due to the greater number of casualty and urgent cases, while the attendances in all the special departments have increased. In the last report it was suggested that though the out-patient department was seldom improperly taken advantage of by persons who were able to pay medical men in the ordinary way, as a further safeguard to the public it would be advisable to appoint an out-patient enquiry officer. Miss Thomas was appointed to this post early in 1898, and her report shows that out of the enormous number of 78,000 patients only 54 were rejected as being unsuitable, a satisfactory vindication of the Governors' report last year. Other items in the administrative record of 1898 are the retirement of the former chaplain, the Rev. C. H. Bowden, to accept the living of St. Paul's, Bermondsey, and the transference of the duties of chaplain to the Lord Bishop of Rochester. The duties of chaplain are now carried on from the Collegiate House, St. Thomas's Street.

A new pension scheme for hospital servants has also been prepared and put in motion by the governors.

The heaviest part of the administration for 1898 was, however, the building of the temporary accommodation for nurses, the completion and renovation of Queen Victoria and Dorcas Wards, a new scheme of drainage, and the commencement of a scheme for new laundry and heating station.

In the matter of finance this year's progress has been steady but uneventful. The re-endowment fund has reached the total of £232,500, and the sustentation fund also showed an increase upon 1897, both in donations and subscriptions. Notwithstanding this increase in income the increase of expenditure has been even greater; the total ordinary expenditure was £46,461, or £4,000 more than last year, and the extraordinary expenditure reached the enormous sum of £18,342. This latter sum was all gone in works of permanent benefit to the hospital, principally the schemes mentioned above, viz., renovation of wards, nurses' accommodation, drainage, etc. Early in 1898 the late Mr. H. L. Raphael made the magnificent donation of £20,000 towards a new nursing home, and as much again is required to bring this scheme to a satisfactory conclusion. Mr. Bonsor concludes his report with an earnest appeal for steady help in the future as in the past, as in addition to the huge ordinary expenditure the extraordinary expenditure necessary for urgent improvements must be met at once or in the course of the next year or two.

Among the chief bequests to Guy's during 1898 was one of £5,000 from Sir Frederick Wills, Bart., for rebuilding the medical library, to be called the Wills library.

The latter half of the report is taken up with the usual statistical tables, which are too large and too numerous to quote. The most interesting is the table of the chief items of expenditure. Meat cost £1,753 17s. 7d. Milk £1,165 13s. 8d. Sisters and nurses' board cost £4,249 9s. 8d. Drugs, etc., cost £5,492 18s. 1d., the details of which were set forth at greater length in the Dispensary report which was noticed in our columns a few weeks ago.

It is impossible with the brief space at our disposal here to do justice to the whole of this excellent report, a standing tribute to the acknowledged good management of Guy's. We can only hope that the public will not be led away by the erroneous impression that Guy's has got all it needs. We are still like Oliver Twist, "asking for more," with a very large M.

Papers by Guy's Men.

Experiments with Pane's Anti-pneumococcic Serum. By J. W. H. Eyre, M.D. Durham, and J. W. Washbourn, M.D., F.R.C.P. Lond. *Lancet*, 8th April.

Remarks upon the Operative Treatment of Distended Small Intestine in Acute Obstruction and in Acute Peritonitis, with illustrative cases. By A. Ernest Maylard, M.B., B.S. Lond. *British Medical Journal*, 8th April.

Guy's Hospital Christian Union.

SUMMER, 1899.

COMMITTEE.—K. Anderson, N. N. Haughton, G. N. Meachen, C. S. Morris, J. L. Payne, W. P. Purdom, N. I. Spriggs, G. H. Steweni, C. Tessier.

HON. SECRETARIES.—P. R. Bolus, A. B. Passmore, D. W. Smith.

THE ANNUAL SERMON is preached in the Hospital Chapel on the third Thursday in October, at 4.30 p.m.

THE WEEKLY ADDRESSES on Thursdays, 4.30 to 5.15 p.m., in the Board Room over the Counting House:—

May 4. Special meeting. Student speakers.
" 11. H. W. Oldham (Sec. B.C.C.U.) Subject: "Bible Circles."
" 18. Dr. Grattan Guinness. An address.
" 25. Special meeting. Student speakers.
June 1. Rev. F. B. Meyer. An address.
" 8. Rev. W. R. Mowll. An address.
" 15. Special meeting. Student speakers.
" 22. Missionary meeting.
" 29. Rev. A. E. Barnes-Lawrence. An address.
July 6. Dr. Pye-Smith. An address.
" 13. Special meeting. Student speakers.

The Hospital for Sick Children,

GREAT ORMOND STREET, W.C.

LECTURES FROM MAY TO JULY, 1899.

FREE TO MEDICAL PRACTITIONERS.

Thursdays.

May 4. Dr. Thomas Barlow—Demonstration of Selected Cases.
11. Dr. Lees—Demonstration of Selected Cases.
18. Dr. Fredk. Batten—"Muscular Atrophy."
25. Mr. Bernard Pitts—Demonstration of Selected Cases.
June 1. Dr. W. S. Colman—Demonstration of Selected Cases.
8. Mr. Thos. H. Kellock—Demonstration of Selected Cases.
15. Dr. Lees—Demonstration of Selected Cases.
22. Dr. Voelcker—Demonstration of Selected Cases.
29. Mr. H. Stansfield Collier—"Treatment of Intussusception in young children."
July 6. Dr. A. E. Garrod—Demonstration of Selected Cases.
13 Dr. Francis G. Penrose—Demonstration of Selected Cases.
20. Mr. Donald Gunn—Demonstration of Selected Cases.

The Physicians and Surgeons, Assistant Physicians and Assistant Surgeons give Clinical Instruction to Students of the Hospital at their visits.

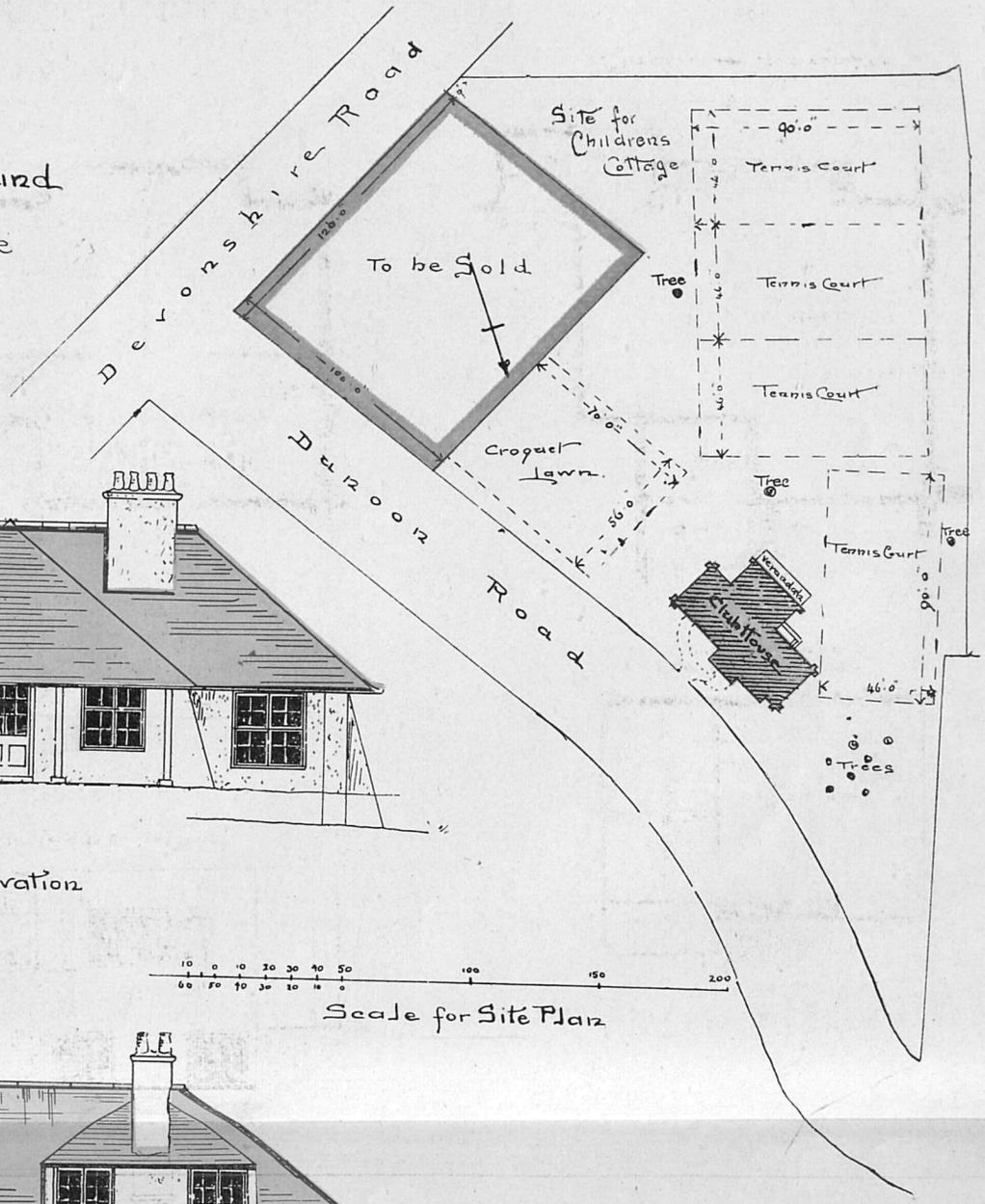
Fee for attendance on the Practice of the Hospital:—
For Three Months ... ... £2 2s.
PERPETUAL TICKET ... ... £3 3s.

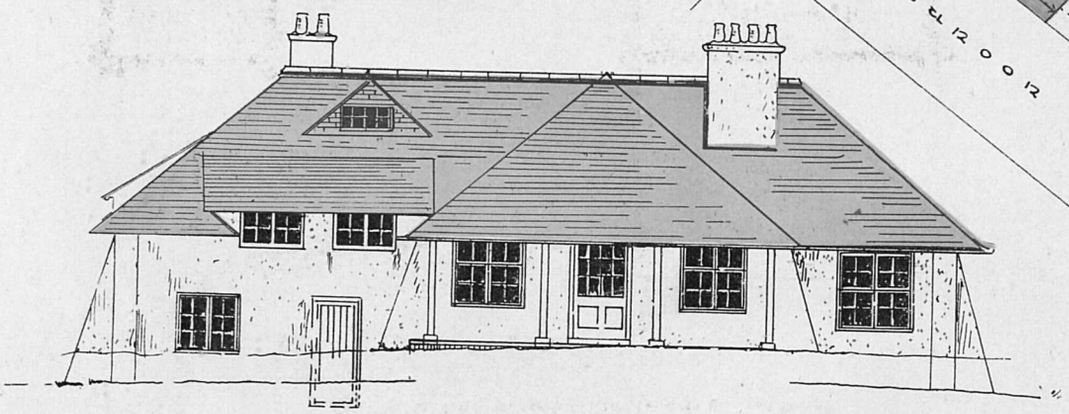
ADRIAN HOPE, Secretary.

Guys Hospital. S.E.

Nurses Recreation Ground

Proposed Club House

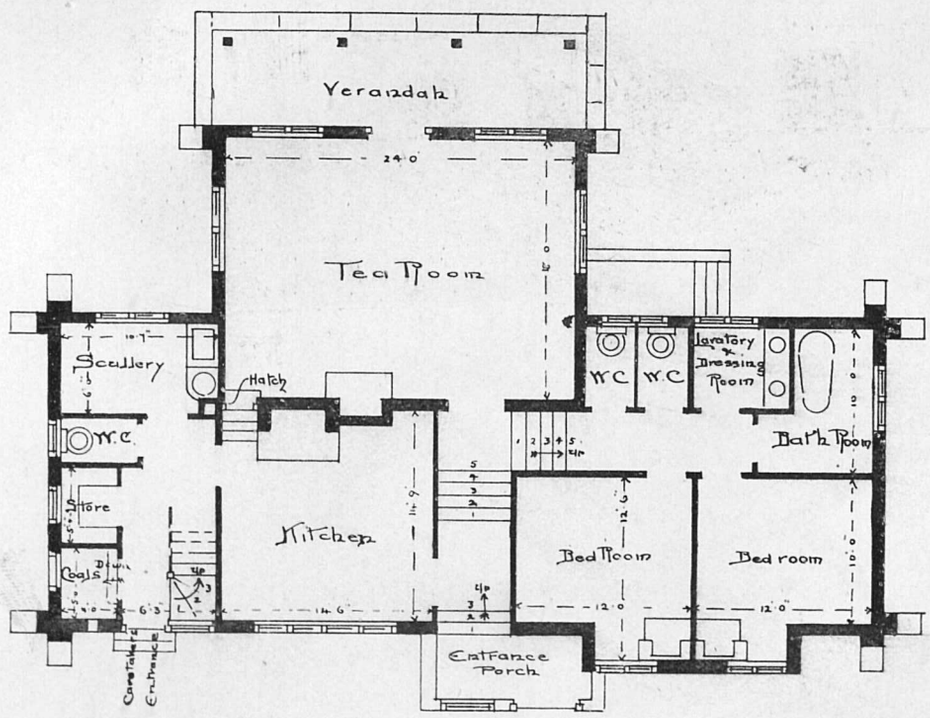




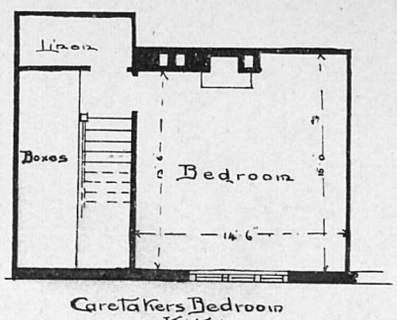
South West Elevation

Scale for Site Plan

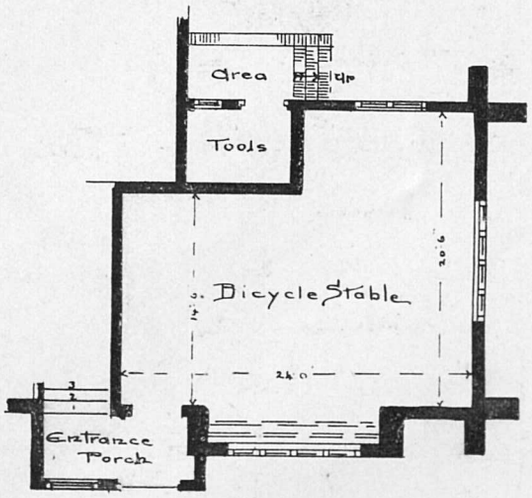
North East Elevation (towards Dunoon Road)



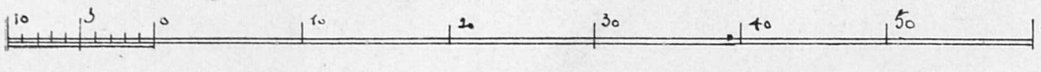
General Ground Floor Plan



Caretakers Bedroom over Kitchen



Plan under Bedrooms &c



Passim.

WE deeply regret to record the sudden and unexpected death of Mr. H. L. Raphael, which took place on May 11th at his country house at Newmarket. He had been slightly unwell for a day or two, but no anxiety was felt by those about him; his sudden death came as a great shock, and caused universal regret upon the Stock Exchange, where he was a well-known and respected figure.

MR. RAPHAEL was appointed a Governor to this hospital in 1898, and in the same year he made the munificent gift of £20,000 towards the building of a new Nursing Home, to be called the Henriette Raphael Home, in memory of his wife. Unfortunately he only lived to see the bare beginning of the scheme he so generously endowed. His death will be a great and lasting loss to the hospital.

ON Wednesday evening next a small and quiet dinner is to be given to Dr. Goodhart by the men at the hospital who have worked under him. It is in no sense a public dinner, and is strictly limited to men still at the hospital and a few old House-Physicians of Dr. Goodhart's. It is hoped that everybody who can will come to express to Dr. Goodhart the univeral affection with which he is regarded at Guy's, and to make a memorable occasion of the evening.

THE Cricket Season has began fairly well. On May 6th the Eleven met Waldegrave Park at Honor Oak, and Guy's scored 208 to the Visitors' 58, the chief feature of the game being Bowle's bowling (excuse the inevitable apposition) which resulted in the fall of 4 wickets for 12 runs. At the Crystal Palace v. the Palace Club, on May 13th, another victory was scored by Guy's, who defeated the home team by 43 runs. Mr. C. Wetherell played in the first match, but the team has since lost his services as he has gone up to Durham for awhile. Among useful new members of the Eleven may be mentioned Bowle, O'Brien, and Langdale.

WE are requested to state that Dr. E. W. Goodall will be delighted to receive the names of any old Guy's men who would like to play in the Past v. Present Tennis Match on June 17th. Names should be sent to Dr. Goodall, at The Eastern Hospital, Homerton, at an early date.

MR. F. E. FREMANTLE has forwarded to us the list of the Lawn Tennis 2nd VI. fixtures, a very healthy sign of renewed interest. If Mr. Fremantle can infect any of the team with his unbounded keenness and enthusiasm, they ought to have a successful season. In the Tennis Competition there has been a record entry, 26 names were put down for the Championship, 41 for the Singles Handicap, and 22 couples for the Doubles. Altogether, Tennis is in a very healthy way.

WE would call the attention of all recently qualified and senior men to the excellent course of lectures and demonstrations to be given at the Hospital for Sick Children, Great Ormond Street, particulars of which are given in another column. The diagnosis and treatment of children's diseases is quite a special branch of general medicine, a branch which it well pays the general practitioner to know, and know thoroughly. The opportunities for clinical observation should never be neglected, and Great Ormond Street Hospital has an exceptional clinique. The lectures are free to all Medical Practitioners.

OF questions of etiquette and procedure there is no end, and rightly too, for a regard for other people's rights, and strict adherence to the rules of the game, is one of the characteristics upon which we pride ourselves here at Guy's. The latest problem is that concerning Tracheotomies and who is to do them. Of course, no resident has a right to do a tracheotomy; the operation is the Surgeon's, and he can give it to whom he pleases, but it is always advisable to have a definite rule, for the guidance both of Surgeon and House-Surgeon, as to whom the operation shall be offered to and who shall accept it.

BEFORE the appointment of the present six Assistant House-Surgeons, the rule was simplicity itself. All tracheotomies all over the hospital were given to the House-Surgeon for the week, and he was usually supposed to surrender the third operation, which he did, to the House-Physician, to give the latter a chance of doing a most essential operation. This scheme answered very well till the last twelve months. Then some Assistant Surgeons suggested, "We have a House-Surgeon of our own now, who is responsible for the surgical cases in the medical wards. Why should not he do the operation in preference to the full House-

Surgeon, and be responsible for the case, as in the usual way?"

This view did not, of course, apply to Clinical, as the Clinicals are responsible for the after treatment of Surgical cases, so the full House-Surgeon for the week is still supposed to do all urgency operations in John and Miriam.

This is how the matter stands at present, and is a cause of much confusion, as there is no definite rule laid down, and no self-respecting man likes to accept and do an operation which he considers is in another man's province. With a view to settling the question, we would invite suggestions as to points of order and etiquette from those in residence at the present.

A semi-official suggestion we have received is to the effect that the rule finally settled on should not break down on occasions. As there are two House-Surgeons always compulsorily on the premises, and the Assistant House-Surgeons do not of necessity live in residence, and as the House-Surgeon for the week is a more competent person than the Assistant House-Surgeon—and it is the patient who is being considered, or ought to be—the House-Surgeon for the week should do all tracheotomies and urgency operations all over the hospital. Planned tracheotomies from laryngeal stenosis, and other operations of a less urgent character, should be given to the Assistant House-Surgeons. But the matter will rest in the present state till sufficient suggestions have been received to lay down a rule which shall not break down on nearly every occasion.

Last Saturday week the hospital scored a great triumph over the anti-vivisectionists at Brixton. The Vicar of St. John's Church came up to the hospital and told some of the men that their Working Men's Club were going to have a debate on the subject of vivisection, and the secretary of the Anti-vivisection Society was coming down to address the meeting. He wanted to know if any men would care to go down and speak for the medical side of the question. Some half-dozen men went down, and a hot evening ensued. Excellent speeches were made for the medical aspect by Messrs. Cleveland, Spriggs and Walker, and the result of the voting was a complete victory for the hospital men by 60 to 9. It is pity that more of these meetings are not conducted in the same open way. There would be less nonsense talked and less perversion of the truth.

In the Southport election, which is to take place on Tuesday, May 30th, the Liberal candidate is Sir George Pilkington, who is one of the most popular men in the division among all classes. Sir George Pilkington is a medical man, an old Guy's man, and a regular and valued subscriber to the Hospital. We wish him every success in the coming struggle.

We publish in to-day's Gazette a plan of the proposed Club House and Ground for the Nurses' Recreation Society. It is situated quite close to Honor Oak Park Station, being about the same distance from it as the Clubs' Union Ground, but in the opposite direction. If the scheme is carried out, it will be a welcome boon to the Nurses; and it seems admirably adapted to their needs, for provision is made upon the plan for four tennis courts and a croquet lawn.

We are officially informed that there is no Nursing News this month. It is surely an unhealthy sign that a community of some 300 ladies should have nothing to talk about. They must be rather dull at times.

Guy's Hospital Dental Society.

A Meeting of the Society was held on March 14th, at 5 p.m., the President, Mr. Hopson, in the chair.

The minutes of the previous meeting were read and confirmed, and the following casual communications were brought forward:—

Mr. Plumley showed an upper model with a supernumerary *in situ*. A dilacerated lower incisor and two dwarfed upper third molars. He also showed models of sarcoma of soft and part of hard palate before and after removal of growth.

Mr. Dowsett showed models and photos of patient with sarcoma of superior maxilla before and after treatment.

Mr. Greenwood showed an upper model with the right lateral showing complete rotation.

Mr. Palmer showed an upper and lower model of well-marked hypertrophy of gums and alveolus.

A good discussion on the communications then followed, after which the President called on Mr. Wartski for his paper on

THE ADAPTION OF ARTIFICIAL DENTURES.

Mr. President and Gentlemen,—It is not my intention to make many preliminary remarks in the way of an introduction. "The proper adaptation of artificial dentures," as the title of my paper denotes, will commend itself to everyone as being very important. The

object in wearing artificial substitutes for the lost natural teeth is, of course, to improve the power of mastication, to give clearness and distinctness to the speech, and to restore to the features the particular character of expression existing before the removal or decay of those essential occupants of the dental arches. There is no branch in our profession that calls for the exercise and mechanical skill and ingenuity in a greater measure than that of constructing such an appliance, and a great deal of a dentist's reputation is dependent upon his skill in this department, for not only has the patient to be satisfied with a well-fitting case, but it must also please the patient's numerous sisters, cousins and aunts.

The excellent teaching we all receive from members on the staff, and adding your own experience, I feel sure that I shall not be telling you anything new. I do not claim to be an authority, nor can I deal with it so fully as the subject commands, but there are a few details in connection with the fitting of dentures successfully which are very imperative and must not be overlooked, to these I should like to engage your attention.

There is apparently a sameness in most cases, but in detail each requires to be studied and treated on its own merits. For the means to be adopted, one must be guided by several important considerations.

Examine the mouth, carefully noting any peculiarities, protuberances, undercuts, hard and soft points. Feeling with the finger to ascertain how much the soft parts yield to, and the hard resist, pressure. The soft parts will require compression in proportion to the amount of yielding, the hard parts will need easing in proportion to the amount of resistance. Location of the muscles must be carefully observed, as it is of great importance to the outlining of the plate, attention to which gives comfort to the patient and prevents the plates from tilting. Another equally important condition is that of a fissure of the vault, commencing in the soft palate and extending at times into the hard palate. This fissure is often so narrow so as to deceive one as to its existence and depth, which can only be discerned on close examination. These fissures run usually through the centre of the palate, but occasionally are found double, one on either side of the central prominence; careful attention must be paid to this condition to avoid a space between the denture and the mouth, and to exclude the air which would interfere with the adhesion of the plate.

During the examination of the mouth very frequently will be found prominent points of the alveolar process, due to uneven resorption after the extraction of the teeth; these should be removed. The attachment of the frænum of the lip to the alveolar process frequently being very low, it may interfere with the upper margin of the denture; this should receive surgical treatment.

The extraction or retention of teeth or roots requires careful attention; it is often very puzzling which teeth to extract and which teeth to retain. To this, no set rule will apply; one must be guided by the age of the patient, the condition and character of the teeth, and if those teeth which we wish to retain will be of much utility to the patient.

The extraction or retention of teeth or roots depends on the advantages to be gained; when they cannot be made healthy they are to be extracted.

The dentist is often intent on his work and is thinking of it, but the feelings of patients should not be forgotten. Therefore when one has an elderly patient to treat, it is advisable to retain as many teeth as possible, thereby avoiding more pain and inconvenience than is absolutely necessary. Loose teeth should be extracted, as they are useless for the attachment of clasps, and only irritate and cause swelling of the surrounding tissue and are of detriment to the fit of the case. On the other hand, if the patient is young and the teeth are of a frail and chalky character and the period of their existence is likely to be a short one, under such circumstances it is advisable and more conducive to the future well-being of the patient to extract all the teeth; by doing so future trouble is avoided, and the mouth is in a sound and healthy condition.

Teeth that have lost their opponents and have become elongated, should be extracted; they can serve no useful purpose, and are only detrimental to the fit and appearance of the denture.

The presence of salivary calculus on the teeth should always be removed.

Good sound roots, in good positions, should be retained and crowned to form supports for the artificial teeth. The canines should always, if possible, be retained, even if the crowns are badly decayed the roots should be preserved and crowned, as they not only retain that facial expression which it is almost impossible to regain with an artificial denture, but they also guide and stay the bite. As a rule the canine roots are the most solidly fixed in the maxilla. They can be easier treated for their preservation, because Nature seems to resent their removal. In the selection of roots for crowning, they must be firm and free from disease; they should be brought into the healthiest possible condition to prevent the occurrence of disease in future. Whenever an artificial plate is fitted over retained roots, which the patient refused to have extracted, these roots should, in all cases, be thoroughly rendered aseptic and filled, otherwise they would generally be the exciting cause of local disturbance and cause a foul and fœtid breath. In a case where a denture is fitted over the roots, the patient should be instructed to have the roots examined once a year, for fear of elongation and bearing too much upon the weakening of the plate.

The canines should be extracted when they cannot be brought to a healthy condition, or when so abnormally situated as to interfere with the proper fit of a denture, *e.g.*, when interfering with the bite, protruding to such a degree as to cause disfigurement, or if dropping inward, or if occluding inside the lower teeth, or a tilting from or towards the median line, thus making it difficult to adjust artificial teeth between the natural ones, or if elongated giving a marked canine expression to the face.

Bicuspids, except when on both sides of the mouth and useful as clasp attachments, should be extracted. Molars should be retained, as they afford a means of support by clasping in the mouth.

In the lower jaw, it is a good plan to retain as many teeth as possible, with possibly the exception of a single central or lateral. The other teeth afford a means of support for a denture, till the patient may become used to its management. In the selection of teeth to be used for clasping, we must take into consideration their position, shape and soundness. The teeth selected should not only be strong and in a good position, but only certain parts of them must be utilised, to facilitate the ready insertion and easy removal of the denture, and also that these teeth which we select for retaining the denture in position should last a good length of time. The neck of a tooth is not the proper position for a clasp, unless the tooth is short and cone shaped, as the presence of a wire round it soon causes its destruction and also irritates the gum. Broad bands should always be used for the bicuspids and molars.

The patient should be instructed to thoroughly cleanse the inner surface of the clasps, and on our part it is desirable to polish well the inside of the clasp. It is better to crown the tooth when it is intended to use clasps, as the action of the clasp either by wear or the deposition of food held next the tooth causing decay, therefore crowning will preserve the teeth and make them valuable to the support they give to the denture.

After the extraction of teeth, the gums should be allowed to absorb and harden before a permanent denture is fitted; it may extend from two to six months and even longer, that depends upon the severity of the operation. It is advisable to prescribe an astringent mouthwash, such as Tannin and Myrrh, etc., and instruct the patient to rinse the mouth frequently, in order to thoroughly disinfect and render aseptic the large cavities left after the removal of the teeth, as they are favourable seats, especially the lower jaw, for the collection of food, which prevents the rapid healing of the gums.

After the extraction of a large number of teeth, it is necessary to insert a temporary denture; they are of great benefit to patients. In order to make them successful they should be so made that they can be worn with comfort. The advantages to be derived therefrom are:—

1st. They are useful for mastication, if a long period has to elapse before a permanent set can be worn.

2nd. Articulation, which is of utmost importance to people engaged in business.

3rd. The original facial expression is preserved, which the patient would otherwise lose to a great extent if left too long without teeth.

4th. Appearance. Patients objecting to be seen by their friends, minus their teeth.

In the upper set, it is better to extract the molars and second bicuspids some weeks before it is intended to insert a temporary set, as during the first few weeks the greatest shrinkage takes place. These gums having healed, then the remaining front teeth should be extracted, the impression taken at the same sitting. The necks of the artificial teeth should fit into the sockets of the recently extracted front teeth, and in the bicuspid and molar region, the vulcanite should be carried over the gum. Or, the impression may be taken with the natural front teeth still standing, and the teeth cut off the plaster model, and sockets made to receive the necks of the artificial teeth.

The advantages to be gained by the above methods are as follows:—

I. The plate can be inserted the same day that the teeth are extracted.

II. The exact arch which Nature originally assigned to the particular mouth is maintained.

III. The very natural appearance, after the outer wall of alveolus is absorbed, the teeth fit closely to the ridge.

IV. This method is admirably adapted for partial cases, *e.g.*, four front teeth.

Provided care is taken that the teeth are well fitted high up into the sockets (in partial cases) even after the space of two or three years there is no space between the gum and the teeth.

It is not advisable for artificial gum to be used in the case of the front teeth, just after the teeth have been extracted, as the mouth appears to be too full, and looks very unnatural, as the alveolar ridge not having been absorbed, the artificial gum is certain to show; when they have been worn for some time after the gums have become absorbed, the ridge becomes flabby and the mucous membrane of lip is drawn into the space between the plate and ridge. This generally occurs in the front and not the back of the mouth. For lower temporary sets, it is better to entirely cover the gum with rubber, the lower plate having to depend upon its retention by its contact with the ridge, making the use of artificial gum all round almost indispensable. The lower jaw not being so prominent as the upper the thin layer of vulcanite is not so noticeable. The length of time which a temporary set should be worn is not longer than a year.

The taking of impressions.—A very able paper upon this subject was read last year by a member of this Society (Mr. Bartholomew), so I shall not enter into any details, but there are one or two points which I should like to call your attention to, and these I know are debatable. The two great essential points in making artificial teeth are, to have a good impression and good articulation. Undoubtedly the best impressions are obtained from plaster of Paris.

Mouths which are soft and flabby are difficult to fit satisfactorily. In such cases in edentulous mouths, plaster is the wrong material to use, composition being far superior to plaster in these cases. When a plaster impression is taken of a mouth at all flabby, no proper adhesion can be obtained from such a model. The soft parts must be pressed by the plate as they are pressed by the impression.

In the lower jaw in which the ridge is hardly perceptable, the following is a good method of taking an impression:—Place the tray in position containing the plaster of proper consistency, and holding the tray in this position request the patient to move the jaw as in mastication allowing the tray to follow each movement. This is done until the plaster is just on setting point; on removing the tray there will be observed on the impression small grooves, elevations and depressions, corresponding to the depressions of the muscles, also depressions and elevations of the jaw, and when the plate is made it will fit accurately and will not be displaced during mastication.

To prevent nausea in taking impressions.—A few drops of spirit of camphor on the tongue will relieve almost instantly, so that an impression can be taken without trouble for the most sensitive patient.

Permanent artificial teeth.—In the making of artificial dentures you must make your work harmonize with the general appearance of the patient. Study your patient in full face and in profile so you are better able to appreciate what is missing and to remedy the defects.

The development of the alveolus is one of the main factors of the clearness of enunciation in speech, and this depends upon the presence of teeth, because as you are all aware that when the teeth are lost, the alveolus becomes absorbed, having no longer any function to subserve, thereby all distinctness of articulation is lost. Therefore, in making a denture, restoration must be made not only of the teeth, but also of the alveolus. Not only should care and artistic skill be exercised in getting the artificial teeth into proper position; in setting them up great taste and skill can be exercised. A more natural facial expression can often be obtained in mounting, by having the centrals slightly overlapping, or one of the front teeth nicely filled with gold, or a tooth slightly twisted, a vacant space left between the teeth. The teeth may be cut to square edge, and various other devices afford ample scope for artistic work and ingenuity; the contour of the facial muscles restored, but attention should be given to the lost lingual portions of the alveolus upon which distinct speech depends.

The tip of the tongue should be in immediate contact with the palatal arch behind the incisor teeth, as the enunciation of most of the sounds of articulate speech depend upon the ability to control the emission of air in the incisive region. Clearness of speech, therefore, depends upon the delicate adjustment of the tongue to this space, when the incisor teeth have been lost and the alveolus becomes absorbed; in the majority of cases the tongue will fall short of contact, hence, the inability to pronounce certain sounds. Therefore, to ensure perfect speech, a true restoration of the alveolus, and the proper position of the teeth is the ideal at which a dentist should aim. Therefore it is necessary prior to any operation to take an impression of the mouth in order to obtain a good idea of the position of the teeth, and shape, so that the artificial denture may be made to conform to the original teeth and alveolus which are about to be removed. Therefore, if the plate be made too thick behind the incisors, where the tongue comes in contact with the palatal arch, then the speech will be thick.

If the plate is not thick enough in this position, then the tongue will not properly close the space, hence a constant hissing and sibillation will take place in articulation. Therefore, great attention must be bestowed upon the lingual part of the denture as the clearness of speech largely depends upon this. And, as before mentioned, every case must be studied from its individual standpoint.

It is a good plan if one has to extract a front tooth to retain it for reference as to size and colour, and for this purpose it should be kept in water.

The size and colour of the upper teeth should be chosen first, the lower set should be selected, the canines of which, when placed edge to edge with the uppers, should fit in between laterals and canines, this will cause the first upper bicuspid to meet between the first and second lower bicuspids, and second upper bicuspid between the second lower bicuspid and first molar, which is the articulation of the natural teeth.

The greatest difficulty in fitting a full set for an edentulous patient is to get the correct height of the teeth, and a proper bite, especially in an aged person where there is great movement in the lower jaw. A good plan is when taking the impressions at the same time to obtain an approximate bite by placing a piece of composition or beeswax, softened and shaped into a fairly thick roll, rather far into the mouth, so as to leave the anterior part of the gums free, and request the patient to bite into it gently until the lips meet naturally. When the models are cast, fit into the wax bite and fix in position in a slab articulator of plaster or composition. If we are going to make the teeth on gold or dental alloy, the plates should be struck up, if on vulcanite meter metal two thicknesses be struck up, thereby we gain a double advantage, (1) a very rigid base-plate for trying in, (2) the rugæ are well reproduced on the lingual side. Then all the teeth should be mounted on the lower plate and the six fronts in the upper with wax blocks behind to oppose the lower teeth. By this means we are able to see whether the natural contour of the lips and cheeks and the lingual portion of the alveolus have been restored. The great advantage to be gained from the wax bite is, you have the teeth probably very nearly correctly placed; and this is a good guide in getting the right distance between the jaws, let the upper front teeth come as low as meeting of the lips when the face is repose. This may have to be modified, and it is best observed by talking to the patient and seeing how they look when conversing and laughing.

A word about suction chambers.—These are not only useless, but they also irritate the palate, the mucous membrane becomes spongy and soon fills up the suction chamber.

The centre of the palate in most cases is hard, and the only portion of the jaw which never changes or yields to pressure; as the alveolus gives way, the plate will rest

there and rock and prevent proper adhesion and stability. In making a metal plate, a good plan is to cover the hard centre with a thin film of wax, chamfering the margins to a thin edge. In vulcanite cases it is necessary to dry the model and flush a thin layer of plaster over this hard centre, the plaster being of a watery consistency, and should be painted on with a camel's hair brush. Another method is by placing a piece of metal foil in that position on the model before vulcanizing, or, after the plate is vulcanized to use a large bur and remove a portion of the rubber from the centre of the palatal surface.

In those cases where the centre of the palate is quite soft, there is no necessity to make any change at all, but to fit the plate closely to its entire surface.

For a very absorbed ridge, a suction chamber may be made in this way. Dry the model and mix some thin plaster, and with a fine camel's hair brush build up a half-round ridge about the width of a wire F gauge, along what is left of the original ridge, leaving off about a quarter of an inch from the end of the previously marked off plate on both sides.

This can be used in both metal and vulcanite cases. The plate will firmly adhere by means of this narrow and continuous air chamber.

It is necessary for a plate covering the tissues to be a good conductor of thermal changes. Therefore it will be seen that gold platinum or dental alloy are much superior to rubber as artificial dentures, the latter being a very poor conductor. And also a plate should possess the greatest possible strength in the least possible space; here, again, vulcanite is deficient in the requirements of the case, showing the relative advantages of metal over rubber.

In vulcanite cases, in order to ensure an absolutely perfect fit, the case should be vulcanized on the original model of the mouth, it is of much importance to reduce the thickness of the plate to a minimum, so as to fill the mouth as little as possible, but without decreasing the strength of the plate.

To prevent rubbing roots. In many cases where there are prominent roots standing, which the patients refuse to have touched, a good method is, after the impression is taken, fill the roots with copper amalgam, taking care that the amalgam is left standing above the surrounding modelling material, and a little roughened. This should be left standing for an hour or two, for the amalgam to set, and the impression then cast in plaster. In such cases it will be found that the roots will not get rubbed at all.

In conclusion, I beg to thank you, Mr. President and Gentlemen, for your kind indulgence in so attentively listening to my paper. In order to make this meeting more interesting, I hope we shall have a good discussion.

Another discussion followed, in which the President, H. T. Morris, Messrs. Wilkes, Aldis, Searle and Steveni joined. Mr. Steveni then passed a vote of thanks to Mr. Wartski for his excellent paper, thus terminating the meeting.

In Lighter Vein.

Of the many suggestions for designs in the new flooring of Colonnade, the best to our mind is that which combines utility with ornament. "To the Dispensary—Down the steps and 4th door on the left"—would be an immense boon if inscribed every few yards. And think how many visitors would say "What a good idea!" It is certainly no worse than hanging texts in the ward, as after all, they direct you to a spiritual dispensary. Other people say, Why not utilise it as an advertising medium? Such as "Have you those nasty sinking feelings with a furred tongue and loss of appetite? Try Mist. Acidi Co. *The* Tonic," or "Wind Pills! Wind Pills! Wind Pills!" "There is nothing like Pil. Creasoti." It would serve to impress elementary treatment on young students if nothing else.

Suggestions have been pouring in this week, and here is another that seems worthy of consideration. A correspondent writes, that in order to display greater accuracy in diagnosis, and to prevent the "hedging" always noticed in the post-mortem room, why not arrange a list of betting odds in the report as to the nature of a disease? Thus: 7 to 2 on Sarcoma, 2 to 1 against Gumma, 15 to 4 against Tubercle, 100 to 8 against anything else. As it is, in a case of this sort, a surgeon says he thinks it may be sarcoma, puts the patient on iodides, and calls in a physician to examine the lungs with regard to phthisis, and so if it is sarcoma, he says he knew it, if a gumma he points to his treatment, and if tubercle, remarks "Ah! we were afraid it might be." Now, if he gave the odds, he would be more or less pledged to one diagnosis. And how much more entertaining the reports would be—"May 12th. The tumour seems smaller to-day. Gumma went to evens on, while Sarcoma could find few backers at 5 to 2." And then the result if written in the style of the sporting papers, would do much to enliven the monotony of our life. "Ovarian and Obstruction were strongly fancied before the operation by some, though the stable were backing Malignant Omentum rather heavily. Once in the straight Ovarian came right away, but at the last turn Obstruction drew very close, and finished second, much to everyone's surprise. The rest nowhere."

The human mind in the abstract alters little from year to year. An old Guy's man was going round the medical wards the other day

with a physician, and remarked the clerks playfully auscultating each others' backs and percussing the heads of their friends. "Dull as a board," said one. "Egg-shell crackling," said another. "We used to do that, too," sadly observed the G. P. to another of his time. "M'Yes" came the rejoinder, "and *we* thought it original."

An anonymous friend has kindly forwarded me a copy of "The Zoophilist." I do not know if the paper was sent for review, but I have much pleasure in stating that it is teeming with bright and amusing articles, and is a production that no student of contemporary humour can afford to miss. I have no children of my own, but I have shown it to a friend who has, and he tells me that he would take it in regularly for his little ones, but that in these hard times he is not prepared to pay threepence for a periodical that contains no pictures. The editor might consider this point.

So Dr. Granville Bantock does not believe in antiseptic surgery. The dear old gentleman may be congratulated on hammering another nail into the vivisectionist coffin, and Lord Lister, the foul murderer of thousands of God's own inoffensive microbes, can now go home and hide his head beneath one of his own discredited carbolized towels.

It is interesting to note that on May 24th, the occasion of our dinner to Dr. Goodhart, Sir William MacCormack will also be entertained by his old house surgeons of St. Thomas's. Both functions will probably be brilliant.

Our excellent contemporary "The Outlook" (May 13th) tells the following hospital story :—

A TRANSFORMATION SCENE.

He seemed strangely out of place in the spotless hospital ward. Threescore and odd years of street cadging had made him more like a scarecrow than a human being: only the bright, furtive eyes beneath the neglected thatch of hair spoke of Man, made in God's image.

He stood in dumb amazement before the bed to which the white-capped nurse had led him; for on it lay—not the wife he had come to see—but a stranger, a new and different woman, who yet looked at him with his wife's eyes, and in whose's voice, albeit fainter and less raucous, he recognised the long familiar note.

Before the man's bewildered mind there flitted a vision of the creature who had been his mate for forty years—a figure of dirt and degradation indescribable. But the exquisitely dainty nurse was scarcely more spotless than his wife now. The hand that lay on the bed was the colour of a human hand, and not the brute's paw that he had known. The sheer, unwonted cleanliness of her face quite altered its expression. Her hair was brushed back from her forehead in neat, smooth strands, which alone would have given her an unfamiliar aspect, and the strangeness of the whole was completed by the pink flannel bed-gown which she wore and the spread of white sheet around her. She lay still, grinning at her husband's wonder. A yard away, the nurse enjoyed the comedy in silence, proud of her handiwork.

At last he spoke. With an effort, turning his eyes from the marvel on the bed, he searched for a moment among his rags, and then, with a solemnity befitting the occasion—

"Nuss," he said, clearing his throat, "'ere's fruppence and I knawed it must 'a bin a dreadful job."

"Well, missie," said an out-patient clerk the other day, "What's the matter with you?" And the maiden having been previously instructed by her mother, replied, "Please sir, I've been under the 'orspital twice, onst with Amenia and onst wid the Noo Ammonia, and on Fursday I come so 'orrid on ve leg, and Muvver fought it was a ulster." Truly an interesting collection of diseases for one small girl!

Chapel News.

The next general meeting of the members of the congregation has been fixed for Sunday, June 4th, immediately after the evening service, in the Chaplain's Room. All who are accustomed to worship in the Chapel are invited to attend. At that meeting, besides other business, two vacancies upon the Church Council have to be filled up. Mr. Fremantle has given notice that he will propose an alteration of Rule 2, which runs as follows:—

> "The twelve elected members of the Church Council shall be communicants of the Church of England, and they shall be chosen at a meeting of the members of the congregation, convened by the acting Chaplain, every six months should vacancies arise. Due notice of this meeting shall be given in the Chapel, Colonnade, Nurses' Dining Hall, Hostel, and in the GAZETTE, and the voting at this meeting shall be by ballot."

The amount required for the three panels of the Reredos has now been raised. The two side panels cost £30 each, and the central panel £90—total, £150.

	£	s.	d.
Amount raised for side panels	60	0	0
For central panel—			
Donations already acknowledged	88	16	7
Donations received since the last issue of the GAZETTE.....	1	16	6
Total ...	£150	13	1

In the last issue of the GAZETTE it was announced that an anonymous donation of £10 10s. had been given for marble steps in the Sacrarium. Since then Mr. Chas. Barclay has kindly sent a donation of £10. The offertories in the Chapel on Whit Sunday will be devoted to the same object.

The preacher at the evening service on Whit Sunday will be the Rev. J. O. Nash, and on Trinity Sunday morning, at 11 a.m., the Rev. A. G. Locke, Chaplain of St. George's Hospital.

Pass List.

University of Cambridge, April, 1899.

THIRD EXAMINATION FOR THE MEDICAL AND SURGICAL DEGREES.

PART I.—J. G. Taylor, D. P. Watson, L. Wilkin.

PART II.—H. A. Gaitskell.

University of Durham.

EXAMINATION FOR THE DEGREE OF DOCTOR OF MEDICINE.

Charles Hilary Bryant.

EXAMINATION FOR THE DEGREE OF DOCTOR OF MEDICINE FOR PRACTITIONERS OF FIFTEEN YEARS' STANDING.

William Makeig Jones. Alexander Lane.

Final Conjoint Examination, April, 1899.

MEDICINE AND SURGERY.—*H. S. Crapper, *E. B. Dowsett, *W. H. Edwards, *A. D. Lewis, *J. T. M. McDougall, *G. N. Meachen, D. J. Munro.

SURGERY AND MIDWIFERY.—W. B. Hope, L. Wilkin.

MEDICINE.—*W. L. Baker, *J. Howells, J. L. Payne, A. Reid, *J. H. Roberts, T. M. Walker, J B. Walters.

SURGERY.—H. J. M. D. S. Barker, H. W. Bruce, H. N. Clarke, *E. H. Cragg, *J. W. Ensor, R. Fell, B. Instone, A. R. McLachlan, *A. A. Miller, *J. E. H. Parsons, A. W. Penrose, E. R. Row, S. A. Ruzzak, E. W. H. Shenton, *H. C. Sturdy, J. G. Taylor, *O. C. Worthington.

MIDWIFERY.—J. B. C. Brockwell, G. T. Brundrett, E. I. Davis, H. B. Dismorr, J. N. Dyson, C. Edwards, W. McIlroy, L. C. Martin, E. H. Milson, A. G. Osborn, E. E. Parrett, H. M. Reeve, G. S. Simpson, W. G. Stewart, E. J. Tongue.

* denotes completion of examination.

Second Conjoint Examination.

K. Anderson, J. Braithwaite, C. H. Bubb, S. Child, M. W. Cohen, P. P. Cole, W. H. Cole, H. A. Cutler, E. Faulks, J. T. Hicks, G. W. C. Hollist, N. N. A. Houghton, W. W. C. Jones, R. C. Lawry, G. H. H. Manfield, O. C. H. L. Moll, S. L. Pallant, H. T. Palmer, E. Roberts, C. H. Robertson, T. M. Smith, F. L. Thomas, H. Tipping, W. E. J. Tuohy, A. H. E. Wall.

First Conjoint Examination.

PART I.—CHEMISTRY AND PHYSICS.—H. W. Bethell, S. C. Bowle, G. Carlisle, E. Couchman, C. F. Fraser, R. St. G. Seagrove.

PART II.—PRACTICAL PHARMACY.—E. G. Andrew, F. G. Cross, E. I. Davis, H. B. Dismorr, C. Edwards, C. E. Hicks, W. H. Loosely, R. P. Marshall, B. Muir, F. M. Ommanney, L. Pern, S. L. Prall, T. M. Walker, V. M. Wallis, P. H. Ward, G. T. Willan.

PART III.—ELEMENTARY BIOLOGY.—R. G. Anderson, F. Barnes, H. O. M. Beadnell, H. W. Bethell, R. D. Bridger, G. Carlisle, L. Cooke, J. W. Featherstone. R. Franklin, C. F. Fraser, E. J. Gaffney, H. B. German, B. Glendining, F. G. Goble, V. Goulding, B. W. Lacey, E. J. Malim, G. Nunn.

Examination in Elementary Anatomy, March, 1899.

The following gentlemen have passed the above examination:—R. G. Anderson, P. C. V. Bent, K. Black, P. R. Bolus, W. F. Box, H. S. Brown, G. L. Buckeridge, G. Carlisle, L. Cooke, W. L. M. Day, F. W. Fawssett, L. S. H. Glanville, B. Glendining, C. E. Iredell, R. Larkin, F. B. Lowe, E. H. B. Milsom, P. A. Peall, C. D. Pye-Smith, G. H. Rees, F. Rogerson, H. D. Smart, N. Ivens Spriggs, O. B. Travers, C. A. Watson-Smyth, Hugh Watts, B. H. Wedd, H. C. Winckworth, R. M. Wingent.

Preliminary Scientific (M.B.) Classes.

EASTER EXAMINATIONS.

	CHEMISTRY.		PHYSICS.	
1.	H. H. Carter	73	J. H. Clatworthy	84
2.	G. Hamilton	62	H. H. Carter	78
3.	J. H. Clatworthy	58	A. Leeming	72
4.	R. Felton	56	R. Felton	70
5.	M. G. Louisson	54	R. O. Williams	58
6.	E. L. R. Norton	52	M. G. Louisson	51
7.	R. O. Williams	48	C. H. Reinhold	49
8.	A. M. Roome	47	E. L. R. Norton	44
9.	O. S. Norton	42	J. O. Musson	36
10.	A. Leeming	41	A. M. Roome	25
11.	C. H. Reinhold	40	G. Russell	20
12.	R. O. Dowdeswell	33	R. O. Dowdeswell	18
13.	A. B. O'Brien	32	G. Hamilton	17*
14.	J. O. Musson	31	W. P. Purdom	16*
15.	W. P. Purdom	18*	A. B. O'Brien	10
16.	G. Russell	18	O. S. Norton	5

* Absent from written examination.

Maximum marks in each subject (including practical work) 100.

Sport.

Cricket

LIST OF MATCHES.—First Eleven.

Date.	Time.	Against.	Ground.
May 3...	2 0	Trial Game	Honor Oak Park.
„ 6...	11 0	Waldegrave Park ...	Honor Oak Park.
„ 10...	11 0	Hornsey	Honor Oak Park.
„ 13...	11 0	Crystal Palace	Crystal Palace.
„ 17...	11 0	Croydon	Thornton Heath.
„ 20...	11 30	Surbiton	Surbiton.
„ 22...	11 0	Eltham	Honor Oak Park.
„ 27 ..	11 0	Beckenham	Beckenham.
June 3 ..	11 0	Reigate Priory	Reigate.
„ 10...	11 0	Ashby De La Zouch	Honor Oak Park.
„ 14 ..	11 0	Hornsey	Hornsey.
„ 17...	11 0	Past *v.* Present	Honor Oak Park.
„ 23) „ 24)	11 0	Eastbourne.....	Eastbourne.
July 1...	11 0	Reigate Priory	Honor Oak Park.
„ 8...	11 0	Brentwood	Honor Oak Park.
„ 12...	11 0	Gravesend	Gravesend.
„ 15...	11 0	Dunstable Gram.Sc.	Dunstable.
„ 22...	11 0	Brentwood	Brentwood.

GUY'S v. WALDEGRAVE PARK.

This, the first match of the season was played on Saturday, May 6th, at Honor Oak Park.

The visitors unfortunately were unable to bring a full team, and only batted ten men. Guy's won the toss and took first innings on a good wicket, and were dismissed for 208. M. C. Wetherell played very well for 59, and we shall be sorry to lose his services for the rest of the season owing to his departure for Durham. Our opponents only scored 58. S. C. Bowle took four wickets for 12 runs. Scores:—

Guy's.

F. C. Wetherell, b Drabble	6
E. Graham Smith, b Drabble	3
K. V. Trubshaw, c Walbank, b Tucker	37
S. C. Bowle, c Drabble, b Walbank	25
M. C. Wetherell, b White	59
H. R. Grellet, b Drabble	0
G. T. Willan, c sub., b Walbank	26
H. W. Bush, b Walbank	3
R. Willan, b Burningham.....	5
A. H. Turner, not out.....	21
E. W. Strange, c Tucker, b Drabble	3
Extras	20
Total	208

Waldegrave Park.

H. Tucker, c Bowle, b Strange.....	0
Walbank, b F. Wetherell	11
E. Drabble, b Bowle	19
A. White, run out	0
H. Ward, b F. Wetherell	7
A. Cowen, c Bush, b Trubshaw	3
C. Drabble, b Bowle	10
H. Whiffin, b Bowle	2
A. R. Thompson, b Bowle	0
J. Burningham, not out.....	1
Extras	5
Total	58

GUY'S v. HORNSEY.

This match was played at Honor Oak Park on Wednesday, May 10th. Hornsey batted first and scored 263 for 3 wickets. Thanks to fine batting by W. Brewer and A. E. Clarke, and to several mistakes in the field on our part, their innings was declared closed, and they just succeeded in dismissing us with five minutes to spare, for the moderate total of 137. The feature of our innings was the steady batting of Langdale, who, with Saunders made a capital stand for the seventh wicket, and appeared likely to save the match, as twenty minutes before time the score was 130 for 6 wickets. Scores:—

Hornsey.

D. J. Crump, c, Wetherell, b Graham-Smith	11
W. J. Brewer, not out.....	118
A. E. Clarke, c G. Willan, b Trubshaw	88
L. Tubbs, b Trubshaw	1
F. Dent, not out	20
Extras	25
Total	263

F. J. Nicholls, S. King, W. Nimmo, H. Nicholls, E. Adamson, and G. Hart did not bat.

Guy's

F. C. Wetherell, c Clarke, b H. Nicholls	0
E. Graham-Smith, c Clarke, b H. Nicholls	20
K. V. Trubshaw, c King, b H. Nicholls.....	19
S. C. Bowle, c H Nicholls, b Clarke	7
H. M. Langdale, b H. Nicholls	47
G. T. Willan, c Nimmo, b H. Nicholls	15
H. R. Grellet, c Nimmo, b Dent	2
A. Saunders, b Adamson	17
E. Cohen, c Clarke, b Adamson	1
A. Turner, b Adamson	0
R. Willan, not out	2
Extras	7
Total	137

GUY'S v. CRYSTAL PALACE.

This match was played at the Crystal Palace on Saturday, May 13th. Guy's batted first on a rather difficult wicket, considering which, together with the excellent bowling of L. Walker, our total of 158 was quite satisfactory. A promising feature was the batting of the three new men Bowle, O'Brien and Langdale, who made over half the runs between them. We had the satisfaction of dismissing our opponents for 115, and winning by 43 runs, our victory being due to a great extent to the much improved fielding. In spite of the balls bumping very much, Graham-Smith kept wicket most creditably. Scores:—

Guy's.

E. Graham-Smith, c Todd, b Walker.....	4
R. C. Poyser, c Todd, b Walker	8
K. V. Trubshaw, c & b Walker.....	13
S. C. Bowle, c Bicknell, b Walker	29
A. O'Brien, st Todd, b Bicknell	31
H. M. Langdale, b Walker	25
W. Dennant, b L. Turner.....	15
G. T. Willan, c Bicknell, b Walker.....	10
H. R. Grellet, run out	8
E. W. Strange, not out	6
C. M. Cowper, b L. Turner	0
Extras	9
Total	158

CRYSTAL PALACE.

E. G. Turner, c Graham-Smith, b Cowper	5
E. H. Lulham, b Bowle	29
H. L. Turner, c Poyser, b Cowper	6
L. Walker, lbw, b O'Brien	13
G. Bicknell, c Langdale, b Strange	22
W. F. Umney, c Strange, b Trubshaw	24
R. Dillon, b Strange	0
J. Darke, c & b Bowle	6
H. Currey, c Cowper, b Trubshaw	0
A. F. Todd, b Bowle	0
F. A. Glover, not out	0
Extras	10
Total	115

Guy's Hospital Lawn Tennis Club.

LIST OF MATCHES.—FIRST SIX.

Date.		Against.	Ground.
May.	Sat. 6.	Trial Match	Home.
	Sat. 13.	Boundaries	Home.
	Sat. 20.	Blackheath	Blackheath.
	Sat. 27.	Kent L. T. Club... ...	Home.
June	Sat. 3.	Harold	Gipsy Hill.
	Th. 8.	Hornsey	Home.
	Sat. 10.	Redhill	Redhill.
	Sat. 17.	Past v. Present	Home.
	Wd. 21.	Connaught	Chingford.
	Sat. 24.	Chiswick Park	Chiswick.
	Wd. 28.	The Staff...	Home.
July	Sat. 1.	Chiswick Park	Chiswick.
	Sat. 8.	Harold	Home.
	Sat. 15.	Connaught	Chingford.
	Sat. 22.	Wanstead	Wanstead.
	Sat. 29.	Wanstead	Home.

Matches v. Albemarle and Inter-Hospital Cup Ties to be arranged later.

SECOND SIX.

May	Sat. 20.	Addiscombe II.	Home.
	Wd. 24.	Gipsies' II.	Stamford Hill.
	Sat. 27.	St. Bart's Hospital II.	Winchmore Hill.
	Wd. 31.	Addiscombe II. (2 pairs)	Croydon, 5.15.
June	Sat. 3.	St. Thomas' Hospital II.	Home.
	Sat. 10.	F. E. Walker, Esq. VI...	Home.
	Sat. 17.	No match (1st vi. Past v. Present).	
	Wd. 21.	St. Bart's. Hospital II. ..	Home.
	Sat. 24.	Gipsies' II.	Home.
	Wd. 28.	Sydenham II.	Sydenham.
July	Sat. 1.	St. George's Hospital II.	Home.
	Sat. 8.	St. Thomas' Hospital II.	Chiswick.
	Sat. 15.	Surbiton II.	Home.
	Sat. 22.	Putney II.	Home, 3 p.m.
	Wd. 26.	Sydenham II.	Home.

THE COMPETITIONS.

The entry is larger this year than it has ever been. For the Championship there were 26 entries. The draw for this competition is already posted, and the first round is to be played off on or before Saturday, May 27. The draw for the Single Handicap which has an entry of 41, and the Doubles Handicap (22 couples) will be posted by Saturday.

At the Inter-Hospital Lawn Tennis Club meeting held on May 15th, A. C. Pearson (George's) was re-elected as Secretary, and the dates fixed for the Cup Competition were June 18, 19, 20.

Dr. Goodall, who is getting up the "Past" team to meet us on June 17th, would like to hear from any "past" men who are willing to play in that match. Dr. Goodall's address is The North Eastern Hospital, Homerton.

GUY'S v. BOUNDARIES.

Played at Honor Oak Park on May 13th, and resulted in a win for the Boundaries by 6 matches to 3, 12 sets to 7, 113 games to 87. We were not quite at full strength, Wacher's absence necessitating the rearrangement of the second and third couples.

P. S. Mandy and H. K. Lacey lost to C. H. Carter and E. L. Bristowe, 9–11, 1–6; beat G. J. Hogg and G. S. Francis, 8–6, 6–3; beat H. B. Lawford and E. W. Story, w.o. *L. Cooke and C. N. Jupp lost to Lawford and Story*, 9–11, 6–2, 3–6; lost to Carter and Bristowe, 10–8, 0–6, 3–6; beat Hogg and Francis, 6–4, 6–4. F. G. Cross and F. B. Manser lost to Hogg and Francis, 3–6, 6–4, 4–6; lost to Lawford and Story, 2–6, 1–6; lost to Carter and Bristowe, 2–6, 2–6.

Births.

PENDRED.—On May 5th, at Lebanon Gardens, Wandsworth, the wife of Berthon Fleming Pendred, L.R.C.P. Lond., M.R.C.S., of a son.

VINEY.—On April 30th, at Harcourts, Chertsey, the wife of J. E. Viney, M.B. Camb., L.R.C.P. Lond., M.R.C.S, of a son.

Marriages.

ENSOR—COX.—On May 16th, at Minchinhampton parish church, by the Rev. E. L. Bryans, Cecil Arthur Ensor, L.R.C.P. Lond., M.R.C.P., younger son of John Arthur Ensor, surgeon, of Tisbury, Wilts., to Irene Margarita Cox, daughter of the late Edward Gordon Cox, and Mrs. Webb Hawell, of Hyde Brae, Gloucestershire.

FAGGE—METCALFE.—On the 10th inst., at Christ Church, Lancaster Gate, Charles Herbert Fagge, F.R.C.S., younger son of H. W. Fagge, of Lutterworth, to Beatrice Dora Metcalfe (late Sister Accident), youngest surviving daughter of the late Michael Metcalfe, of Sydney, N.S.W.

HANCOCK—SWEET-ESCOTT.—On April 19th, at the parish church, Leigh, Worcester, by the Rev. W. Escott, rector and father of the bride, assisted by the Rev. L. R. Hancock, brother of the bridegroom, and the Rev. E. P. Rowlands, William Ilbert Hancock, F.R.C.S. Eng., of Wiveliscombe, Somerset, to Margaret Hay Sweet-Escott.

WILLS—TUBBS.—On May 2nd, at Emmanuel Church, Plymouth, by the Rev. Robert Thompson, vicar of Longcott (cousin of the bride), assisted by the Rev. The O'Shea, and the Rev. W. J. Leigh-Phillips, Walter Kenneth Wills, M.A., M.B., B.C. Cantab., L.R.C.P., M.R.C.S., fifth son of Samuel D. Wills, of Bristol, to Kathleen Isabella Tubbs, youngest daughter of Charles Foulger Tubbs, Beechfield, Plymouth.

ED.—H. L. E.

Contents.

	PAGE
TWO CASES OF BRONCHIECTASIS: Clinical Lecture by Dr. F. Taylor	221-226
NURSING NEWS	226
HOSPITAL NEWS	227-228
PASS LIST	228
THE DINNER TO DR. GOODHART	229-230
NOTICES	230
PASSIM	231-232
GUY'S HOSPITAL CLUBS' UNION	232-233
NURSING NOTES	233-234
AN OPERATION IN A COUNTRY PRACTICE	234
RECENT ADDITIONS TO THE DENTAL MUSEUM	234
IN LIGHTER VEIN	235
CORRESPONDENCE: Medical Co-operation	236
BRITISH MEDICAL ASSOCIATION	236-237
REVIEWS	237-238
SPORT: Cricket—Guy's v. Croydon; Guy's v. Surbiton; Guy's v. Beckenham; Inter-Hospital Cricket Cup Draw. Guy's Hospital Lawn Tennis Club—Guy's v. Blackheath; Guy's v. Kent; Guy's 2nd VI. v. St. Bartholomew's 2nd VI.; 2nd VI. v. Addiscombe	238-240
FROM THE GAZETTE'S SPECIAL PATHOLOGIST	240
PAPERS BY GUY'S MEN	240
APPOINTMENTS	240

Calendar of Coming Events.

June, 1899.

Sat. 3.—Messrs. Howse and Jacobson's take-in; Drs. A. C. Lewis and T. T. Kelly; Cl., J. T. Dunston.
Last day for applying to Registrar for Form of Entry for Intermediate M.B. Lond. Exam.
G.H.C.C., I., Reigate Priory, 11 a.m., away.
II., St. Bart's., 2.30 p.m., away.
G.H.B.C., Run to Maidenhead. Meet at Elephant and Castle.
G.H.L.T.C., Harold, away.
Hos.-Scho. C.C., Corpus Christi, home.

Mon. 5.—Exam. for Treasurer's Gold Medals begin.
1st and 2nd Year's Dental Students' Exam. in Conservation Room for Prizes, at 9 a.m.
2nd Year's Dental Students' Clinical Exam. for Prizes at 2 p.m.

Tues. 6—Last day for sending in Fees and Certificates for 1st and 2nd M.C. Camb. Exam.
Mr. Rowell's Demonstration on Anæsthetics, 12 noon.
G.H.S.C., City of Westminster, away.

Wed. 7.—1 p.m., Clinical lecture by Dr. Shaw.
G.H.C.C., II., Royal School of Mines, 2.30 p.m., home.

Thur. 8.—Messrs. Davies-Colley and Symond's take-in; Drs., T. P. Thomas and J. L. Whatley; Cl., W. L. Baker.
July Appointment List closed.
Application to Medical Office for Schedules for the Second Conjoint Exam. to be made not later than this date.
1st Year's Dental Students' Exam. for Prize, at 2 p.m.
G.H.L.T.C., Hornsey, home.
G.H.M.P.U., Address by Rev. W. R. Mowll.

Fri. 9.—1 p.m., Clinical lecture by Mr. Symonds.

Sat. 10.—Last day for applying to Registrar for form of entry for Pre. Sci. Lond. Exam.
1st and 2nd Year's Dental Students' Laboratory Exam. for Prizes, at 9 a.m.
G.H.C.C., I., Ashby-de-la-Zouch, 11 a.m., home.
II., Croydon, 2.30 p.m., away.
G.H.L.T.C., Redhill, away.
G.H.B.C., U.H.B.C. v. London B.C., Sheen House.
Hos.-Scho. C.C., L.B.&S.C.R. Electric, away.

Mon. 12.—Cambridge 1st and 2nd M.B. Exams. begin.

Tues. 13.—Schedules for Final Conjoint Exam. to be left at the Medical Office not later than this date.
G.H.S.C., Tadpole, home.

Wed. 14.—1 p.m., Clinical lecture by Dr. Shaw.
G.H.C.C., I., Hornsey, 11 a.m., away.

Thur. 15.—Messrs. Lucas and Lane's take-in; Drs., J. S. S. Perkins and J. C. J. Da Silva; Cl., G. N. Meachen.
G.H.S.C., Lewisham, home.
G.H.M.P.U., Special Meeting.

Fri. 16.—1 p.m., Clinical lecture by Mr. Symonds.
Special Exam. for Operative Prize, Conservation Room at 9 a.m.

Sat. 17.—G.H.C.C., I., Past v. Present, 11 a.m., home.
II., Clapham United, 2.30 p.m., away.
G.H.L.T.C., Past v. Present, home.
G.H.B.C., Golding-Bird Cup Race, Sheen House.
Hos.-Scho. C.C., St. George's, Brockley.

Guy's Hospital Gazette,

JUNE 3, 1899.

Two Cases of Bronchiectasis.

CLINICAL LECTURE BY DR. F. TAYLOR.

March 4th, 1899.

GENTLEMEN,—We have in the wards at the present time one case, and we have quite recently had another, both of which are examples of the interesting condition known as Bronchiectasis, or Dilatation of the Bronchi.

The first case is that of a child, aged three, who was admitted on February 16th, and was stated to be the youngest of a family of eleven. The father has always remained quite well, but the mother is at the present time in bed with bronchitis. No suspicion of phthisis can be obtained. Of the other ten children five have died, but the cause of death is unknown; the remaining five have always been strong and well. The illness of this particular child seems to have dated from birth. When only a few days old it had a very bad cough, and was given medicine by the medical man for bronchitis. This cough

never became much better, but in spite of it the patient grew fairly strong until the commencement of 1898, when he became much more irritable and feverish. He was admitted into Champion Hill Infirmary in April, 1898, and remained there for seven months. Three days after discharge from the infirmary the child had to be removed to a fever hospital, for diphtheria, where he remained for seven weeks, returning home on January 1st of this year. From this date he has gradually been getting worse. During the early part of January he had a bad cough, and for ten days had diarrhœa. During the last fortnight the cough has become worse, being both more severe and at shorter intervals, and often continuing until the patient retched or vomited, bringing up some greenish-brown, foul-smelling, and slightly frothy phlegm. For the last two weeks the patient has wasted considerably, especially about the arms and legs, and has been very feverish. The breath has been foul, and during the last week the expectoration has been more offensive, and streaked with bright-red blood. The child has taken its milk well, but the bowels have been rather constipated.

On admission, the child is very ill, and the temperature is 104·2°; the pulse 156, and the respiration 56. He is small, anæmic, and wasted, especially about the extremities, and there is marked clubbing of the fingers; the abdomen is full, the mucous membranes are faintly livid, and the child has slight inspiratory distress, with some sucking in of the intercostal spaces on the left side. It has a frequent, short, dry cough.

The upper part of the right chest in front is decidedly flattened, and moves but little on respiration. The left side moves well, and the lower intercostal spaces show slight sucking in during inspiration. Percussion gives a good note posteriorly on the left side, but an impaired note over the upper part of the sternum, and quite a dull note over the lower part. On the right side a dull note is obtained over the whole area. Posteriorly, on the left side, the note is good. On the right, in an area extending from the apex along the vertebral border of the scapula down to the eighth rib, and passing outwards and forwards into the right axilla, there is a high pitched, almost tympanitic, note. Elsewhere, over the right of the chest, a dull note is obtained.

Auscultation yields on the left side for the most part supplementary breathing; but in the left axilla, between the sixth and ninth ribs, and bounded in front and behind by the axillary folds, is an area of bronchial breathing, with a few consonating râles. Posteriorly, on the left side, the breath sounds are normal. On the right side, from the apex to the sixth rib in front, bronchial breathing is heard, but there are no râles nor rhonchi. Posteriorly, and in the right axilla, is an area of high-pitched resonance, and loud bronchial breathing is heard. The râles in this area are most numerous, all medium-sized and consonating. Near the spine, between the fourth and seventh ribs, the breath sounds are all of a somewhat hollow, bronchial character, and the râles have occasionally a somewhat metallic sound. No bruit d'airain can be obtained. At the base below the eighth rib, the breath sounds are deficient, with a few distant râles. There is loud bronchophony over the area of bronchial breathing, but no pectoriloquy.

With regard to the circulatory system, there was no evidence that the heart was displaced in any direction; it appeared to occupy its normal position. The spleen was enlarged, the abdomen was distended, and some big veins were visible.

As time is very short, I think I will not read the whole of the very full report which Mr. Swan has made of this case. It will suffice to say that the child remained with us until February 25th, when it died, that is, nine days after admission. During that time it had a temperature ranging between 100° and 103°, and the condition of anæmia and prostration continued. The cough was frequent, and it was especially liable to occur whenever the child turned over on to the left side. As long as it lay on its right side it was comparatively comfortable. The odour of the patient's breath was very frequently offensive.

There were variations in the prominence of the bronchial breathing, and especially in the quality of the râles, and there were slight differences in the percussion note. Sometimes it was more, or less, tympanitic in particular areas than it had been before. For the most part the condition that I have represented persisted, viz., dulness over the right side of the chest, bronchial breathing over a large area of the same side, mixed with varying conditions of râles more or less loud, and of varying degrees of vocal resonance. On one occasion, some expectoration was obtained and examined; it showed the presence of streptococci, but contained no tubercle bacilli.

During the morning of February 25th, the child became cyanosed, and died quite suddenly the same day. There was no evidence

of acute pneumothorax. A post-mortem examination was made, and you may now see on this plate the two lungs from this child; they present very good examples of the condition known as bronchiectasis, or dilatation of the bronchial tubes. I have also on the blackboard a diagram or drawing which is a rough copy of an excellent drawing from the right lung that Mr. Swan has made in the report.

In the upper lobe are two large cavities, with sloughing, or gangrenous surfaces. They look even now of a blackish-grey colour, and there is a whitish layer of fibrous tissue around them, a kind of fibrous cyst, as it were, to the cavity. Here is another cavity in the apex of the lower lobe. These large cavities are really the outcome of extreme dilatation of what were once perfectly healthy tubes. In addition, scattered through the lung, in the lower lobe especially, are distinctly widened and dilated tubes. In other parts the lung is almost entirely solid, partly from more or less recent bronchopneumonia, and partly from fibroid change. This sufficiently accounts for the fact that over that area we had dulness, and that we heard those varying conditions of bronchial breathing and râles—the bronchial breathing being partly due to solid lung and partly to the cavities; and the râles partly to pus in the greatly dilated tubes, and partly to pus in the much less dilated tubes in the lower part of the lung.

In the left lung there are some dilated tubes, but they are not dilatations that have gone on to the size of those found in the right lung.

A careful consideration of the lesions of the lungs will show you that they are not tubercular. No tubercles can be found in the lungs; there is no caseation of the bronchial glands, though they are slightly inflamed; and the purulent sputum was free from tubercle bacilli.

The second case of which I wish to speak to you is that of a man, twenty-seven years of age, who is admitted for pyrexia and dyspnœa. His father died of consumption; he does not know where his mother is; he has a brother and sister who are both healthy. He has for years had a chronic cough which becomes worse every winter, but is relieved when the summer time comes. He had whooping cough when a child. He was admitted into Stephen ward in 1896, under my care, and the following is an abstract of the report which was given of his case:—"For the last three years the patient has been losing flesh in winter and recovering it again in the summer. The day before admission he coughed up about half a pint of blood for the first time. He has had night sweats for some years. On admission, he presented signs of an affection of the whole of the left lung, with a basal cavity. The right lung is quite healthy. Briefly stated, the conditions over the left lung were: diminished movement, increased tactile vocal fremitus, impaired resonance, prolonged expiration, bronchophony, and crackling râles and rhonchi, with a patch of bronchial breathing at the angle of the scapula. The cardiac impulse is two inches external to the nipple, in the fifth left space. The patient has clubbed fingers. The sputum was repeatedly examined for tubercle bacilli with a negative result."

On one of these diagrams is indicated the condition of this man's chest when he was under me three years ago. Râles are represented at the upper part of the left lung, at the lower part of the left lung, at the lower part of the axillary region, and over the greater part of the left lung behind. In the middle zone of the left lung behind there was dulness, and over the angle of the scapula there was an area of hollow breathing, with other evidence of a cavity. There was resonance over the præcordial area, where there ought to be dulness, and the heart's impulse was felt some distance to the left of the nipple line. Since leaving the hospital he has been, according to our report, fairly well, with occasional cough. He does not remember having been exposed to damp. He continued well up to February 18th, when he began to feel unwell. On the 19th he had a headache and no appetite. On the day of admission, 20th February, he began to vomit, and brought up everything he took. He also had violent paroxysms of coughing, and brought up quantities of blood-stained sputum, and had severe pain in the cardiac area when he coughed. He was worse all day, and was brought up to the hospital in the evening. On admission he obviously had some recent pleurisy over the left side of the chest, and some on the right side, but during the few days he has been in the hospital these pleuritic signs have disappeared, leaving the condition of the chest not very much different from what it was before. He has dulness, which is, no doubt, more extensive, both upwards and downwards, than it was during his previous stay in hospital; and there are râles over the same area. The crackling râles under the left clavicle are apparently not so extensive as on the previous occasion, but at that point there is a small area of bronchial breathing. Then over the angle of the scapula, in the same position as before, he has pronounced hollow bronchial breathing, with crackling râles. While the centres of disease

are the same as before, there has been some enlargement of their areas. The sputum has been examined, and no tubercle bacilli have been found.

The patient has to our knowledge had these conditions for three years; probably they have a duration of much greater length.

When he was in before, the heart's beat was found to be two inches external to the left nipple. Yesterday, on very careful examination, we found the impulse in the fifth intercostal space, exactly horizontal or on a level with the nipple, and three inches outside it. There was another impulse in the sixth intercostal space, a little more than three inches outside the vertical nipple line, so that the heart continues to be displaced, and, according to measurements yesterday, is farther out from its normal position than it was before.

He is a healthy looking man, but has occasionally the appearance of cyanosis, or blueness, especially about the lips. He has a good colour, an adequate amount of flesh, and does not look as if he were the subject of chronic phthisis of years' duration. He has very much clubbed fingers.

When he came in the temperature was 103°, being associated, no doubt, with his recent attack of pleurisy. The temperature has been gradually falling, during the first week of his admission, to normal, and now it is subnormal, and has been so for the last four days, up to March 1st. Probably for the last week he has been entirely free from temperature, though he continues to cough, and spits up almost pure green pus with very little mucus and only a small amount of air bubbles.

Bronchiectasis means dilatation of the tubes; and the subject is divided systematically into the following:—Cylindrical dilatation of the tubes, fusiform dilatation of the tubes, saccular dilatation of the tubes, and moniliform dilatation of the tubes. We have to deal, on the present occasion mainly with saccular bronchiectasis, and we will confine ourselves to that variety.

So far as the causation of bronchiectasis is concerned, I do not know that any very important difference is made between the various kinds; at any rate between the saccular and fusiform variety. The whole subject of the causation of bronchiectasis is undoubtedly a difficult one. It presents somewhat the same difficulty as emphysema does. Much discussion has taken place as to whether it is the result of inspiratory or expiratory force. You have to consider whether it is the fault of the bronchial tube that it yields, or the fault of something else that pulls the tube out of its place. It is said that bronchiectasis is invariably secondary to some other disease of the lung or tubes, and it is highly probable that inflammation of the walls of the bronchial tube precedes it in most cases, and that thereby the resistance of the tubes to various distending agents is diminished.

Undoubtedly the most common antecedents of bronchiectasis are the various inflammations which affect the bronchi, and the pulmonary substance, and even the pleura; in other words, bronchitis, pneumonia and pleurisy. But while those diseases are frequent, the number of people who have bronchiectasis, of the type we have been speaking about, is comparatively small. And therefore there must be, as it were, some local force in operation at the particular points at which this dilatation takes place.

There is another way in which practically it is very important that you should remember bronchiectasis may be brought on, and that is, by an obstruction of the bronchial tubes. If you have an incomplete obstruction of the bronchial tubes persisting for a long time, a local bronchiectasis may be produced; and a local bronchiectasis which begins as cylindrical or fusiform rather than sacculated. The distension of the tubes may be so extreme and continued, with such secondary changes, that you may get practically the same series of physical signs as you get in this marked case of saccular bronchiectasis. I remember a case of malignant disease of the lungs resulting in pronounced bronchiectasis, where considerable collections of pus were formed, and this pus, stinking pus, was expectorated in large quantities for some time before the death of the patient: and a case of syphilitic stenosis of one of the bronchi, in which a similar dilatation took place, and in which physical signs, indicative of cavities in the lung, were present in the lower lobe for a long time before death.

We now come to the physical signs, which must, of course, vary with the extent of the lesions and the degree of dilatation, Where the dilatation is considerable, and in a saccular form, there are the signs of one or more cavities: high-pitched resonance or tympanitic note, more or less hollow bronchial breathing, crackling or gurgling râles, bronchophony and pectoriloquy. If abundant fibrous tissue has formed either preceding or subsequent to the dilatation, there may be a corresponding amount of dulness, and the percussion note over a large cavity may be modified by the amount of secretion temporarily retained in the cavity. Over other parts of the

affected area where dilatation is less marked, the lung may be perfectly resonant, but the breath sounds are almost entirely obscured by abundant gurgling crackling and squeaking râles, produced by the passage of air through the secretion contained in dilated tubes as yet not sufficiently large to give the signs of a cavity.

In long-standing cases with extensive development of contracting fibrous tissue, the more affected side of the chest may be shrunken or retracted, and the heart displaced.

In the retracted chest, the physical signs of cavity, and the abundant coarse râles, there is, of course, a near resemblance to phthisis, but there are often differences which may enable a diagnosis to be made. But what is most noticeable is that in bronchiectasis there is not the same tendency to the apex of the lung being affected as in phthisis; the dilated bronchi are more commonly found in the lower lobe of the lung, and also, though less prominently, in the middle zone. You will notice in the specimen of the child's lung that the apex is entirely free: I find three-quarters of an inch in this small lung in which there are no dilated bronchi at all. Had the patient suffered from a similarly extensive phthisis, that upper inch would certainly have been affected. It is true, phthisis does not always begin at the actual apex of the lung, but some distance below; but with extension of the disease the apex is certain to become involved.

Further, in bronchiectasis we often have one lung affected very much and the other very little. In phthisis the lungs are unequally affected, but it is only in very slowly progressing cases of fibroid phthisis, that the disproportion between the disease on the two sides of the lung is so great as it is in bronchiectasis.

Now, with regard to the symptoms. In bronchiectasis the patients have a cough which is often aggravated by position. The explanation of this cough being aggravated by position is, that a quantity of pus collects in one of the cavities, and if a position is assumed which enables the pus to run out into the healthy and sensitive bronchial tubes, these are stimulated, and the cough is produced thereby; whereas if the patient remains quiet the irritating pus would lie at the base or lowest part of the cavity, and does not cause cough until it accumulates in a much larger quantity.

In the case of the man now in the ward, the sputum is a green purulent fluid. But there are cases in which the sputum is partly purulent mucus and partly frothy mucus, and tends to separate into two layers, the frothy portion lying on the top of the purulent portion. Then the expectoration contains various constituents, pus-corpuscles, bronchial epithelium, bacteria, fatty and acid crystals, Charcot's crystals, and other elements which are sometimes found in this disease, as well as in some conditions of gangrene of the lung.

Another interesting and important feature in connection with bronchiectasis is that the patient may have hæmoptysis, and this accentuates the resemblance of the disease to phthisis, at any rate. The child, you will remember, was spitting small streaks of blood, but the man came in practically because he had hæmoptysis just before his admission. It occurs in a sufficient number of cases to make it useless as a distinction between phthisis and bronchiectasis.

Then again fever is variable. Both of these patients have had fever. This may be due to recent pneumonia, as in the case of this child probably, or to recent pleurisy, which was present in the adult patient; but it may also arise from septic absorption of the purulent contents of the bronchial tubes. In this man the inflammatory lesions subsided, and now he is practically free from pyrexia.

One very important feature associated with bronchiectasis is that many of the cases do not present the appearance of phthisical patients; they are not wasted, but are frequently well nourished, and have a good colour, or, at any rate, are not anæmic; at the same time, however, there may be some cyanosis, blueness of the lips, of the nose, and perhaps of the tips of the ears, and of the cheeks.

Another feature common in bronchiectasis, in a high degree, is clubbing of the finger ends; it was present in both these patients.

Moreover, it is a disease which may last a very long time. In the case of this man we may infer that it has lasted five or six years. The child is reported to have been ill from birth, and we may suppose that its illness began with bronchitis, and that the condition of bronchiectasis was soon developed. There are cases on record in which patients have lived twenty, forty, or even fifty years, with the physical conditions and signs of bronchiectasis, but no doubt these are exceptional.

Well, now, how do the patients die? They may die from extensive hæmoptysis, from broncho-pneumonia, and also from pneumothorax. The latter is to a certain extent prevented, because the pleural adhesions are so commonly present, but it certainly happens.

And if you look at this lung you will see that these cavities are very near the surface, and you will quite understand that this patient might have got a pneumothorax at no very distant date. They may also die from various cardiac complications, from septic absorption, from ulceration of the bronchial cavities into the substance of the lung, and from gangrene of the lung.

I have here some more diagrams, as I thought it might be useful to draw your attention to two or three other cases, in order to show you the general similarity of the conditions in patients suffering from bronchiectasis. In 1896 there was a boy who presented himself for admission to the Asylum for the Deaf and Dumb. He was twelve years of age, and he had apparently a ruddy country face, and he was certified by a practitioner in the neighbourhood as being quite well, and in a fit state to go into the Asylum. When I examined him at the Asylum he presented a number of râles over the whole of the left chest. My first thought was that the boy had phthisis, but he appeared to be perfectly well nourished to an extent that was unlikely if one lung had been so extensively tubercular. However, I recommended the Asylum not to admit him, as he would probably give them cause for anxiety. A good deal of trouble had been taken about his election, and certain persons were very much interested in him, so that as a compromise I took him into the hospital here to observe the case more closely. While in the hospital he presented the conditions indicated on this diagram. There were numerous râles all over the left chest; and under the left clavicle, in the left axilla, and at the upper part of the lower lobe behind there were points where one got a cracked-pot note, and other signs suggestive of cavities. The boy remained in the hospital six weeks, and expectorated remarkably little; he had no rise of temperature and appeared to be perfectly well. He was accordingly admitted to the Asylum, and was found to be practically in very good health for the most part, except that on entering the Asylum his cough became aggravated and he had to be put in a separate room. Subsequently he went down to the school at Margate, and he actually died about two years after going there. I have no information as to whether any post-mortem was made, nor have I any further note about him.

Another case is illustrated in this diagram. It is the case of a patient who was in the hospital at the end of 1896, in Mary ward, and who had been ill for six years. She came in for hæmoptysis. She had purulent expectoration, and marked clubbing of the fingers and the physical signs shown here. There were crackling râles over the left chest, dulness over the left chest, and bronchial breathing to such a degree as to give rise to a diagnosis of one cavity under the left clavicle and another at the left base. She never sweated at night. Her temperature was 99°. There is, as you will notice, a close resemblance between this case and the last one I described. The patient died at the end of that month, and the diagnosis of bronchiectasis was confirmed at the post-mortem examination.

Let me summarise the difference that one finds between phthisis and bronchiectasis. Usually patients with bronchiectasis have a very long history, and during that history they have not been laid up with the general constitutional disorders that mark phthisical patients. They sometimes have sweating at night, but very often none. They have a cough, but they expectorate pus, which is sometimes offensive; and sometimes their breath smells owing to the presence of this pus in the cavities. They do not waste and lose flesh, or have anæmia to the same extent as if suffering from tubercular phthisis.

The tendency is for the lesion to affect the base, or the middle zone, rather than the apex. And if there are apical cavities they are probably not continuous with the other cavities. In nearly all these cases there was a want of continuity between the lesions. In some of the cases the lesion is in the lower lobe alone, and has not presented itself in the upper lobe at all.

Then, finally, we have in the present day a test which is generally conclusive, namely, that of examining for tubercle bacilli in the sputum.

Time does not allow me to take up the subjects of prognosis and treatment.

Nursing News.

On May 18th, Nurse Hockley (who has gained her three years' Certificate) came before the House Committee, and was appointed Staff Nurse to Bright Ward.

Probationer Simpson was appointed Head Nurse in Stephen Ward on May 30th, in the place of Nurse M. Gray, who is about to join the Private Nursing Staff.

During June three Sisters will be away for their holidays, and their places will be supplied as follows:—Sister Patience by Sister Louisa (Night Sister); Sister Lazarus by Nurse Lambert; Sister Martha by Nurse Wallace; Night Sister by Nurse Harding.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

CASES UNDER DR. PYE-SMITH.

MARY 25, 33. Exophthalmic goître.
28. Diabetes mellitus.
29. Mitral regurgitation and stenosis.
34. Infective endocarditis.
37. Mitral and tricuspid regurgitation. Ascites and anasarca. Enlarged liver. Bronchitis.

PHILIP 22. Acute rheumatism. Pericarditis.
24. Bronchitis simulating phthisis.
25. Mitral regurgitation and stenosis. Tricuspid regurgitation.
29. Chronic bronchitis.
30. Progressive muscular atrophy.
38. Dysphagia. Malignant stricture of œsophagus.
39. Nephralgia. ? Calculus.
40. Acute rheumatism. Presystolic bruit.

CASES UNDER DR. TAYLOR.

MARY 38. Neuritis.
39. ? Stomatitis.
40. Exophthalmic goître.
42. Carcinoma of stomach.
43. Growth of liver.
44. Chorea.
45. Chlorosis.
46. Broncho-pneumonia.
47. ? Duodenal ulcer.
48. ? Gastric ulcer.
50. Empyema.
Cot 57. Eczema.

STEPHEN 1. Pleuritic effusion. Recovery.
2. Acute rheumatism. Recurring joint pains. Mitral regurgitation.
3. Post influenzal headache. ? Meningitis. ? Abscess.
6. Acute Bright's disease.
8. Pains in right thigh and leg. ? Cause.
10. Intra-thoracic growth.
11. Bright's disease.
13. Mitral regurgitation.
15. Abdominal tumour.
18. Empyema. Operation.
20. Phthisis. Both lungs.

CASES UNDER DR. PITT.

MARY 3. Acute rheumatism.
7. Chorea insaniens.
9. Subacute rheumatism.
12. Empyema.

STEPHEN 24. Emphysema.
25. Hæmorrhagic gingivitis.
29. Phthisis. Hæmoptysis.
32. Diabetes mellitus.
33. Cerebral hæmorrhage.
34. Chorea in adult.
35. Pericarditis.
40. Phthisis.

"Clinical."

3. Appendicitis. Suppurative peritonitis.
4. Aortic aneurysm.
5. Cerebellar tumour.
6, 26, 27, 32, 33, 34. Lobar pneumonia.
7, 18. Empyema. Streptococcus longus.
8. Tuberculous peritonitis. Intestinal obstruction.
35. Tuberculous meningitis.
36. Tuberculous broncho-pneumonia.
12. Focal myelitis.
13. Lymphadenoma.
20. Mitral stenosis and regurgitation. Cardiac pneumonia.
28. Suppurating hydatid of liver.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

NAAMAN 1. Strangulated femoral hernia. Kelotomy.
9. Ankylosed knee. Old fracture of neck of femur.
10. Undescended testis and infantile hernia. Castration.
12. Sarcoma of metatarsus. Syme's amputation.
16. Renal calculus.
17. Vesical calculus.

DORCAS 2. Secondary cancerous axillary glands after amputation of breast. Excised.
5. Foreign body (a penny ingested) in cæcum.
8. Dermoid cyst.
8. Carcinoma mammæ.
12. Bilateral tuberculous breasts.
13. Villous growth of bladder.
15. Nævus on face.

CASES UNDER MR. DAVIES-COLLEY.

JOB 3. Mastoid abscess. Antrectomy.
4. Necrosis of ribs.
7. Osteitis of os calcis.
8. ? Caries of ilium, with abscess.
10. Fractured patella.
11. Sacro-coccygeal tumour. ? Intestinal fœtal remains.

JOB	23.	Double cyst of epididymis.
	25.	Femoral exostosis.
LYDIA	1.	Tuberculous elbow.
	6.	Hydatid of liver.
	10.	Lupus nasi.
	11.	Tuberculous breast.
	12.	Carcinoma recti.
	14.	Fractured femur.
	17.	Carcinoma mammæ.
	Cot A.	Cleft palate.
CORNELIUS	1.	Fractured femur.
	10.	Fractured femur.

CASES UNDER MR. LUCAS.

LAZARUS	4.	Appendicitis.
	6.	Stricture of œsophagus.
	7.	Epitheliomatous glands in neck.
	9.	Stricture.
MARTHA	3.	Carcinoma mammæ.
	5.	Tuberculous elbow.
	7.	Cerebral abscess.
	8.	Fractured femur.
	14.	Tuberculous ankle.
	19.	Dislocated ulna.
	20.	Carcinoma mammæ.
	21.	Perinephritic abscess.
	22.	Epithelioma of scalp.
	Cot A.	Fractured femur.
ASTLEY COOPER	9.	Abdominal injury.
	10.	Pott's fracture.
	11.	Fractured femur.
	12.	Pott's fracture.
	18.	Dislocated ankle.
	21.	Fractured femur.
	26.	Fractured ribs and sternum.
	27.	Fractured ribs.
	28.	Ruptured intestine. Laparotomy.
	29.	Ruptured liver.

CASES UNDER MR. GOLDING-BIRD.

LUKE	6.	Renal calculus.
	8.	Multiple papillomata of rectum.
	10.	Sarcoma testis. Castration.
	11.	Enlarged prostate.
	13.	Right inguinal colotomy for colitis.
	14.	Tuberculous knee.
	15.	Talipes equinus. Paralytic.
	16.	Sarcoma of neck. Excised.
	20.	Gonorrhœal synovitis of knee.
CHARITY	2.	Carcinoma mammæ.
	3.	Umbilical hernia.
	8.	Lipoma.
	9.	Ruptured urethra.
	13.	Hip disease.
	14.	Sarcoma of femur. Periosteal. Furneaux-Jordan's amputation.
	21.	Carcinoma mammæ.
	Cot A.	Talipes equino-varus.
ASTLEY COOPER	5.	T shaped fracture of humerus into elbow.
CORNELIUS	11.	Fractured frontal. Surgical emphysema.
	17.	Fractured tibiæ.

CASES UNDER MR. JACOBSON.

NAAMAN	20.	Semitendinosus bursitis.
	22.	Growth of œsophagus.
DORCAS	20.	Tuberculous kidney.
	20.	Exophthalmic goître. Partial excision.
	22.	Sarcoma of groin. Excised.
	Cot B.	Cleft palate.

CASES UNDER MR. SYMONDS.

JOB	17.	Recurrent sarcoma of tonsil.
	19.	Ulceration of fauces and adenitis. ? Tuberculous. ? Syphilitic.
LYDIA	19.	Parenchymatous goître. Excised.
	20.	Stricture of œsophagus.
	Cot D.	Retro-pharyngeal abscess.
RUTH	—.	Syphilitic perichondritis of larynx.

CASES UNDER MR. LANE.

LAZARUS	12.	Renal calculus.
	13.	Displaced semilunar.
	14.	Tuberculous knee.
MARTHA	10.	Ankylosed elbow.
	11.	Appendicitis.

CASES UNDER MR. DUNN.

LUKE	1.	Focal epilepsy.
	2.	Recurrence in parietal scar after pylorectomy for cancer of pylorus.
	3.	Irreducible omental inguinal hernia.
	18.	Acute hæmorrhagic pancreatitis. Laparotomy.
CHARITY	23.	Irreducible femoral hernia.

Pass List.

University of London, May, 1899.

M.B. PASS EXAMINATION.

FIRST DIVISION.—A. H. Carter.

SECOND DIVISION.—F. J. H. Cann, A. E. Clarke, H. E. C. Fox, P. McK. C. Wilmot.

L.D.S. England Examination, May, 1899.

J. R. S. Ash, P. E. Chandler, A. J. Gwatkin, A. D. Hopkins, E. R. Howlett, A. Hughes, J. G. McAlpin, E. B. Marshall-Frost, H. W. Morris, M. P. Nathan, S. H. Olver, P. H. Hayes Palmer, A. E. Rowlett, T. F. Ryan, E. P. Uttley, F. Warlow, E. B. L. White, J. A. Whittington, C. F. Witcomb.

The Dinner to Dr. Goodhart.

ON Wednesday evening, May 20th, Dr. Goodhart was entertained at dinner in the College Dining Hall by his old house physicians and the men still at the hospital who had worked under him. Over seventy men were present, and the majority of Dr. Goodhart's nineteen house physicians. Mr. A. D. Fripp, who was his first H.-P., was unavoidably absent, but among those present were Dr. J. H. Bryant, Dr. Hickman, Dr. Still, Dr. Daldy, Dr. H. A. Munro, Dr. Every Clayton, Mr. C. D. Edwards, Mr. H. T. Hicks, Dr. Spriggs and Dr. Panting.

Dr. Goodhart's last H.-P., Mr. A. J. Cleveland, in the chair.

After dinner the toast of "The Queen" having been drunk, Mr. Cleveland rose to propose the toast of the evening, "Dr. Goodhart," and spoke as follows:—

In proposing the toast of the evening, I should like to offer some explanation as to why we have met here to-night. The invitation which Dr. Goodhart so kindly accepted was given by those of his old clerks at present at Guy's, and any of his old house-physicians who could be present. So that we are in no way representative of that large number of Guy's men who have known Dr. Goodhart as a teacher and a friend. But though we are not representative in number, I am sure we are in sentiment, and I think we are only echoing the thoughts of all who know Dr. Goodhart when we take this opportunity of expressing to him our affection and admiration for him as a man and a physician, and our sincere regret that circumstances have compelled him to part from us, in a sense. We have all worked under Dr. Goodhart in some capacity or another, and there is not one of us that has not learnt something from him—something which cannot be found in books. I am sure that when the days we have spent here have become a memory, one of our proudest boasts will be that we "worked under Goody." I ask you to drink long life and prosperity to Dr. Goodhart.

The toast was drunk amid tremendous enthusiasm, everybody singing "For he's a jolly good fellow," at the top of their voices. When the noise had died down Dr. Goodhart rose to respond, and was again greeted with a prolonged outburst of applause. He said:

Mr. Cleveland and Gentlemen,—I read the other day in Mr. Wheatley's new edition of Pepys' diary, to the effect that the use of words by Mr. Pepys was sometimes peculiar, and I suppose that we have many of us noticed that, as a language grows in age, so the value of the meanings of words is liable to extend over a wider range. And surely this must be so with the word "quiet," for Mr. Cleveland in conveying to me your very kind message that you wished me to dine with you, said it was to be a small and quiet dinner, and here I find myself in a room full, and you greet me with such enthusiasm, that I wonder what an unquiet dinner would have been.

It was but the other day that I was up in Liverpool, and met there an old Guy's man, now a white-haired and reverend-looking senior, although younger than I, and I fancy that I rather astonished his wife by saying, "your husband was one of my 'boys.'" He was one of the ward clerks when I had the honour of being surgical registrar some twenty-six years ago. And it is, I understand, by reason of our holding a similar relationship, you and I, that I am indebted for this most pleasant invitation to meet you all here to-night. You wont expect much of a speech from me, for an occasion of this kind opens up a vista of thirty-six years that are gone, and that is an occasion of much tension of thought and feeling.

But, perhaps, you will expect me to say a word as to why I left Guy's. At any rate I should like to do so, for many have said to me, "You're a nice fellow, you get all the good things that the old place has to give you, and then you leave us." But that is a very erroneous way of looking at the matter. You may take it as certain that no one leaves a post on the staff of a great hospital like this, if he can by any means help it. I left you because it was impossible to do the work any longer properly. My house physician and ward clerks wasting their time in waiting for me, unpunctual, haunted me, and Guy's is always strong enough in its younger men to replace those that it sheds.

And this necessity of the seniors is the opportunity of those that are below them. But if anyone congratulates me, as some do, on my having to withdraw from Guy's, I say I am no subject for anything of the sort, on the contrary, I am much to be pitied, and it is very gratifying to find that when the time has come each party to this compact of years is sorry at the parting.

I have not always been held in such esteem. Years ago I was dresser to Mr. Hilton, and did my level best as a dresser. I may say that no one ever did less than his best for Mr. Hilton, for that great teacher, although very kind of heart, could be on occasion very rough of speech. After finishing the appointment, I did as we all do—asked him for a testimonial, expecting, of course, something that would be at any rate cordial, and what came was this: "Mr. Goodhart will make a competent house-surgeon." I gazed long at this epigrammatic utterance, wondering how it would look in print, coming at last to the conclusion that it would not look at all. I returned it to my archives, to bring it out, perhaps, on such an occasion as this, as a sort of refiner's fire, when I might be tempted to indulge in the sin of being over puffed up.

Another rebuff comes to my mind, and that was not so very long ago either. One morning a gentleman came to my house to obtain, as he said, the benefit of my opinion. I told him that it was impossible to see him that day, and that he must make an appointment for another day. He made this no difficulty, and departed. Imagine my chagrin the next morning, when I received a note from him saying that as he particularly wanted to see old Dr. Goodhart, he would wait till he came home. Only one other little episode will I relate, and I do this because it is one in which all of you will particularly realise my painful position, and bestow upon

me your sympathy at the hollowness of the charge! There came to me one day a man and his wife, the man having a somewhat obscure disease associated with chronic jaundice. Having investigated the case, I said I would write to the medical man who was in attendance, but at this they were very unwilling to give me permission, because he had not given the patient what he considered proper attention, and it was with considerable difficulty that I prevailed, and was allowed to write. However, it was at length all nicely settled, and I wrote a long letter to this man, who was a perfect stranger to me. An acknowledgement came back in due course, and how do you think it read? "Sir,—Damn it, why don't you write plainer?" with three or four pages of other abuse at my unfortunate orthography. There are many of these little vicissitudes and makings for humility in the practice of medicine, but what are they all when blotted out by an evening such as this?

I spent part of this afternoon in paying a visit, or trying to, to Kensington Palace, to-day for the first time thrown open to the public, and as I watched the seething crowd waiting for admission, I could not but wonder, and think, and hope that many of those who entered might imbibe some of the healthy influences of its old and best traditions, for healthy traditions mellow and harmonise the rough usages of life. And I always thank God that Guy's is a place of such: and one of ours appears to be that there is no separate caste of teacher and of taught, but all are one and indivisible. A writer in the *Spectator* the other day, in attempting to explain the affection of the people for the Queen, attributed it to the fact that the people know that there is nothing that she would not do for them, and she knows that they know it. A similar spirit breathes, it seems to me, in the air at Guy's. Each of the parties in our body corporate knows that the other has its interests at heart, and I see this in the amount of time and trouble given and taken both by seniors and juniors of my colleagues in attending meetings and committees of all sorts for the good of the hospital and school, and in the kind and hearty goodwill that is shown on all occasions by the students to the staff. I cannot, I am sorry to say, pretend to think that I have been anything but an unfaithful steward in this respect, but I have at any rate the pleasure to-night of being caught up in the bonds that others have forged for me; to this I well know that I owe the gratification which your initiative has given me, and kindnesses such as this, they live for ever in the hearts of men.

Besides so many of my old ward clerks, no less than ten of my old house physicians have come up to night. To them and all of you may I give my warmest thanks, and I will end by drinking the health of each and all of you, may every one of you have health and long life, and that success that my experience of you all tells me you so well deserve. (Loud cheers).

Dr. Goodhart then rose to propose the health of the Chairman, which was also drunk with its full share of vocal honours, and a movement was then made to the Charities' Room. As this was originally built for two people, over fifty made somewhat of a crowd down there, but it in no way marred the enjoyment of the occasion. Messrs. Hicks, Fitz-Hugh, Cazenove, and Miller, sang, and Dr. Goodhart's final departure amid rounds of cheers, brought a most successful evening to a most successful conclusion.

Notices.

GUY'S HOSPITAL MEDICAL SCHOOL.

VACANT STAFF APPOINTMENTS.

The following vacancies for next October are announced:—

One Assistant Physiciancy.
Three Demonstratorships in Anatomy.
One " " Bacteriology and Sanitary Science.
One " " Biology.
One " " Chemistry and Physics.
One " " Physiolgy.
One " " Surgical Pathology.
One " " Psychology.
Five " " Practical Dentistry.
One " " Microscopical Pathology.
One Curatorship of Dental Museum.
One Medical Registrarship.
One Surgical Registrarship.

Gentlemen appointed to the above vacancies will be required to begin their duties on the 1st of October next. Further particulars may be obtained from the Dean. Applications should be sent to the Treasurer, Superintendent's Office, Guy's Hospital, S.E., on or before June 12th, 1899.

Guy's Hospital. (Signed) LAURISTON E. SHAW.
May 27th, 1899. Dean.

LONDON COUNTY COUNCIL.

The Technical Education Board of the Council is prepared to receive applications for a Scholarship in Sanitary Science, of the value of £150 a year, tenable in the Pathological Laboratory of the Claybury Asylum. The Scholarship will be awarded in the first instance for one year, but may be renewed for a second, and possibly for a third year upon a satisfactory report being received from the Superintendent of the Pathological Laboratory under whose direction the Scholar will be required to work.

Candidates, who may be either men or women, must be ordinarily resident within the Administrative County of London. In making the selection preference will be given to a candidate who is a qualified and registered practitioner and has completed his or her academic course. The Scholar must make such arrangements as to residence as will enable his or her whole time to be devoted to the study of *the working and effects of preventable social and industrial causes of insanity.*

Applications containing a full record of the candidate's previous work, and reference to their professional teachers, must be sent to the undersigned not later than Wednesday, June 7th. WM. GARNETT,
Secretary of the Board.

116, St. Martin's Lane, W.C., 17th May, 1899.

Passim.

THE dinner to Dr. Goodhart last Wednesday week was a great success, as it could not fail to be when Dr. Goodhart was the guest. The Dining Hall was quite full, and enthusiasm was everywhere. Nearly all Dr. Goodhart's old House-Physicians were present, commencing with one of his first, Dr. Hickman, and his last, Mr. A. J. Cleveland, taking the chair.

DR. GOODHART'S speech was one of the best and most characteristic we have ever heard, and he gave us some good new phrases. "Puffed-uppedness" was the best, to our minds. His health was drunk with the utmost enthusiasm, and was a real tribute to the absolute affection with which he is regarded by all who have had the pleasure of working with him. After dinner Dr. Goodhart went down stairs according to the time-honoured custom, to the Charities' room, where the evening terminated with an impromptu sing-song.

THE Annual Distribution of Prizes will take place this year on Friday, July 7th, and Mr. Robert Gordon has undertaken to distribute them. Mr. Gordon is a Governor of the hospital, and we may remind readers of the GAZETTE that he was the first to respond to Mr. Balfour's appeal for funds for the purpose of Medical Education and Research.

A LONG list of vacant Staff appointments for next October, is published in our present issue. In some instances the vacancies may perhaps be regarded as nominal, the present holders being eligible and applying for re-election. The facts that one of the vacancies is an Assistant Physiciancy, and that one of the Demonstrators of Anatomy is said not to be applying for re-election, suggest that there will be some important changes in the junior staff, and any man who is ambitious for a teaching post, should send in an application without delay.

THE innate conservatism of all hospital men, despite their political creeds, is well shown by the agitation with which any intended reform is greeted. The rumours concerning the new method of appointing extension dressers, have caused a great deal of discussion, and, on the whole, public opinion is decidedly against the scheme. The resolution, as we understand, is to the effect that no surgeon shall have more than one extension dresser in the future, unless all the other surgeons have one also.

THIS, at first sight, appears to meet all the demands of justice of fair play among firms, for it is intended by distributing the best men among all the firms, to ensure greater uniformity, and a generally higher standard of work than has hitherto been the case.

BUT the objections to the working of this idea, and we are speaking with studied moderation, are many. In a matter such as this, touching as it does the preference uniformly exhibited by the men for certain surgeons, it is difficult to speak plainly without giving offence. But the greatest, as well as the least, live in an atmosphere of criticism, and just as all men, from the day they enter here to the day they leave, are watched and secretly summed up, as it were, by medical councils, committees, etc., so the members of the staff must of necessity be judged by the very men whom they judge, and we think with no less precision.

THE result is the greater or lesser popularity which each individual enjoys, and which guides men to a very large degree in their application for appointments. We understand that extension dresser is a reward given to a man for his record previous to his appointment as dresser. If the best men get what they wish when they apply for a dressership, as their dressing is not considered in the question of extension, the same men ought to get extension for the same reason, the conditions of their application remaining unaltered. Hence, the turning of the man's reward to ashes by giving him extension on an uncongenial firm, is hardly fair. Again, *esprit de corps* is a feeling among a body of men; split up the men and the feeling is gone; the fact that they were associated together gave the men that sentiment, divided, there is no incentive to its continuance.

BUT these columns are no place for a detailed criticism of a scheme at present we believe only under discussion; the *pros* and *cons* have no doubt been well considered before the step was taken. We can only suggest that the proposals would have been received with more approval, if the opinions of all the house-surgeons had been taken, instead of only one, and if the reform was not so obviously personally directed.

THE List of the Inter-hospital Cricket Cup Ties has just been published and will be found in another column. In the first round, Guy's plays Westminster Hospital, and the winner of these two plays the winner of the match between St. Thomas's and Charing Cross, so that with luck we shall meet St. Thomas's early in the season. The exact date is not yet fixed, but the two ties above-mentioned have to be played before June 7th.

ON Wednesday evening next, Dr. Lockhart Stephens has arranged to give a demonstration of Sandow's method of acquiring strength. It will take place in the Gymnasium of the College at 8 p m., and it is hoped that as many men as possible will attend, both to show their appreciation of Dr. Lockhart Stephens and an interest in what is apparently a most successful method of physical training.

WE regret to announce the death of Mr. Henry Bendelack Hewetson, of Leeds, which occurred on May 13th, at Hull. He qualified at the Leeds School of Medicine in 1873, and subsequently came to London to study ophthalmic and aural surgery. For his ophthalmic work he attended the Royal London Ophthalmic Hospital, and he attended Guy's to learn aural surgery, working under the late Mr. James Hinton. He subsequently became honorary ophthalmic and aural surgeon to the Leeds Infirmary, where he continued to practice till his death. He was the author of several books and papers, among which were "The Relation between Sick Headaches and Optical Defects, chiefly Astigmatic, from Diagnosis and Treatment by Glasses, 1885," and "The Localization of Headaches," which appeared as recently as 1897.

MOST readers of the GAZETTE will probably have seen that Sir George Pilkington, whom we mentioned in our last number as a candidate for the parliamentary seat vacant at Southport, has got in, defeating his conservative opponent. We heartily congratulate Sir George Pilkington on his success.

DR. SHARP, of Whitby, an old contributor to the GAZETTE, writes at some length in another column to draw the attention of all Guy's men who are in practice or think of setting up in the North of England to the advantages accruing to them if they become members of the Surgical Supply Association, Manchester. As far as we can see the advantages are great, and the interests of practitioners are guarded by the fact that all but one of the directors of the Association are medical men. Prospectuses and further particulars may be obtained from the Secretary of the Association, 35, Market Street, Manchester.

Guy's Hospital Clubs' Union.

THE Council of the Clubs' Union have much pleasure in presenting the Seventh Annual Report of the progress of the Union, together with a statement of the Receipts and Expenditure since April 1st, 1898.

The total number of members on March 31st, 1899, was 1,953, of whom 1,720 are life members, 200 annual subscribers, and 33 patrons; an increase of 72 since the issue of the last report.

The continued support accorded by the Governors and Consulting and Acting Staff, and old Guy's men, is most gratifying to the Council. We again venture to point out to old Guy's men who have not paid their life subscription of one guinea, the advantages of having their names and addresses in the Clubs' Union Blue Book, which is a useful directory and is much used by members who wish their patients when away from home to be looked after by Guy's men.

During the winter months, Harris, the ground man, has shifted the road at the Brockley end of the ground about six yards nearer to the fence, and by this means the ground has been much improved, and also increased in size for playing purposes. This will be a great boon to the Association Football Club, who will be able now to have a full-sized ground, and to play cup-ties at home. It will also enable the Tennis Club to increase the number of their courts. In the autumn a number of lime trees were planted round the ground, and in a few years will form a pleasant and effective screen, which will be much needed on account of the number of houses which are being built in the neighbourhood.

The agreements with the St. German's Cricket Club, and Travers & Sons' Cricket Club have been renewed. Permission has again been granted to the members of the Guy's Hospital and School Servants' Cricket Club to practice cricket on two evenings in each week during the season.

The Athletic Club held their Annual Meeting on the Clubs' Union Ground on June 22nd, 1898, and the meeting will again be held there this year, in the month of June, the exact date to be announced in a later issue of the GAZETTE.

The best thanks of the Council are due to the officers of the Constituent Institutions, to the Auditors, and to Mr. Croucher and the other members of the School Office Staff for their able assistance.

The income for the year was £2,103 11s. 9d., the expenditure £1,610 11s. 9d., leaving a balance of £493. This large balance is partly due to the fact that three of the Constituent Institutions did not apply for their grants until after the end of the financial year.

Statement of Receipts and Expenditure from 1st April, 1898, to March 31st, 1899.

1898. RECEIPTS.	£	s.	d.	£	s.	d.
April 1st.						
To Balance at Bankers ...	217	15	7			
„ Petty Cash balance in hand	4	4	11			
				222	0	6
Aug. 31st.						
To Subscriptions and Donations from April 1st to August 31st, 1898	308	5	6			
1899.						
March 31st.						
To Subscriptions and Donations from September 1st, 1898, to March 31st, 1899 ...	1192	15	6			
				1501	1	0
„ Grant from Medical School for 1898 ..				100	0	0
„ Grant from Dental School, for 1898 ...				15	0	0
„ Rent from Tenants				90	0	0
„ Rent from Lockers				12	13	0
„ Gate Receipts				16	7	6
„ Blue Book Advertisements				73	4	6
„ Sale of Railway Tickets				66	13	4
„ Deposit Interest				6	11	11
				£2,103	11	9

1899. EXPENDITURE.	£	s.	d.	£	s.	d.
March 31st.						
By Grants to Constituent Institutions—						
Athletic Club	38	7	0			
Bicycle Club	5	13	1			
Christian Union	9	0	0			
Cricket Club	17	6	2			
Debating Society	8	7	4			
Dental Society	9	12	4			
Football Club, Association	14	8	10			
Guy's Hospital Gazette ...	319	15	0			
Guy's Hospital Reports ...	209	5	0			
Rifle Association	12	3	0			
Students' Club	246	1	7			
Swimming Club	3	13	4			
Tennis Club	16	9	4			
				910	2	0
„ Field current expenses ...	212	10	10			
„ Field Rent Account (Interest on Loans)	234	10	0			
				447	0	10
„ Management Expenses—						
Printing and Stationery ...	5	16	8			
Secretarial Expenses ...	47	0	9			
Postage	4	9	0			
Insurance	1	7	0			
Production of Year Book ...	85	7	7			
				144	1	0
„ Railway Ticket Deposit Account ...				66	13	4
„ Rates and Taxes				40	13	5
„ Petty Cash Expenditure				2	1	2
„ Balance at Bankers ...	490	16	3			
„ Balance of Petty Cash in hand	2	3	9			
				493	0	0
				£2,103	11	9

J. W. WASHBOURN, Treasurer.
J. H. BRYANT, Hon. Sec.

Audited and found correct,
THOS. G. STEVENS.
May 15th, 1899. HERBERT L. EASON.

Nursing Notes.

THE nurses want a new library badly; for the collection of books over at their sitting-room is about as satisfying as the literature of a station waiting-room, only not quite so up-to-date. Well, perhaps we are maligning it; there is much Sunday reading, but then all days are not Sundays. There are also several volumes of "Great Thoughts," but not really helpful to ordinary mortals, and some nice but cumbersome volumes of "Harper's Magazine" and the "Century."

We want to mention that no ingratitude is meant towards the College, from which books have been borrowed—and lost, most diligently by us all. However, a few of our most energetic nurses have determined to start a really nice library. The consent of the authorities has been obtained; now we want action and enthusiasm.

The idea is, that the entrance fee shall be a book, not necessarily new, and a small yearly subscription. But just imagine what kind of a collection we should get if intending members brought their offering untrammelled by the guidance of a committee!

Fifty-two volumes of Dicken's "Christmas Carol" (9d. edition), with a sprinkling of his other works. Six damaged volumes of "The Sorrows of Satan." Edna Lyall in abundance, and a dozen Lawrence Humphrys from "Strings" who have passed everything.

Truly, committees are blessed things when they organize these matters for us. We may add that this scheme is still in its youth, not having even blossomed into the publicity of the dining-hall board; but the time will come.

Lawrence Humphry reminds us that serious work is being done at the Nursery. Tea parties are no longer frivolled over; from cubicle to cubicle "the alimentary canal murmurs meanderingly along its course (with variations), whilst the blood feverishly and excitedly circulates in a most original manner." Of course, they all know they are not going to pass, but if they should happen to do so they will all be at the bottom of the list.

If the physicians could wear halos and the surgeons labels [An invidious distinction!—Ed.]

it would prevent awkward mistakes. For the second time, within a few weeks, one of our great men has been evicted by a nurse for being in the ward out of visiting hours. Perhaps the eviction was not quite a success, but the effect upon his feelings must have been the same!

"L'INCONNUE."

An Operation in a Country Practice.

THE following account of an operation on a Strangulated Inguinal Hernia is not written to report any rarity of the case, but to show some of the difficulties encountered in operating in a country practice.

I was called to see an old man one night at 9 p.m. by the following message: "Please would you send grandfather some medicine to make him sleep as his rupture has come DOWN and is paining him and making him very sick!! And will you call round in the morning and see him." Needless to say I did not send the medicine or wait for the morning light to see him.

I found my patient, an old man of 75 years of age, sitting up in bed with flushed face and watery eye (for he had but one) fighting for breath, and the whole room echoing with noisy wheezings and vibrations of a hard, dry, hacking cough. His whole aspect was not a pleasing one with the thought of operation uppermost in my mind. He was obviously suffering from acute bronchitis, and on examining his scrotum it was found dull-red in colour, tense and slightly œdematous. Taxis was tried but not persisted in for it was of no avail, and operation was decided on.

The use of a general anæsthetic was out of the question so cocaine was selected. The skin over the hernia was quickly prepared, and half a grain of cocaine was injected into the tissue at the site for the incision.

The question of illumination then cropped up; nothing but a "shaky" oil lamp could be obtained; but who should hold it? A grandson of my patient was quickly pressed into service, and with the patient sitting bolt upright (for the dyspnœa was so great that he could not even lie back), I started with a bold incision. I had not calculated what effect that incision would have on the "assistant," for the sight so affected him that he upset the lamp on to the bed, and why my patient was not cremated on the spot and thus put beyond all his troubles I know not, but fate was with us. After sundry cursings at our "helper's" carelessness, a carriage lamp was brought up, and he made another attempt "to give us light." Amidst the groans and struggles of our patient, I started to release the hernia, one of many years' standing, and one that many times had been inflamed, if denseness and strength of adhesions of the sac to the surrounding tissues and contents are guides. After great difficulty a small knuckle of bowel was found, and luckily it was in good condition. The neck of the sac was quickly divided, and the bowel returned to the abdomen, a big mass of omentum was removed, and no attempt at radical cure being made, the wound was hurriedly sutured, a small drain being left at its lower angle. The condition of our patient was now one of utter collapse, but after an injection of Liq. Strych. his condition improved. From this time onwards the patient made a good recovery, the wound healed by primary union, and the bronchitis passed off. When I last saw him, eight weeks after the operation, he was up and out "doing a little gardening," and apparently in a better state of health than he had enjoyed for years.

I remember when at Guy's it was often the custom to speak slightingly and jestingly of the G.P.'s treatment of cases, and I suppose that custom is still in vogue; but you budding G.P.'s little know the difficulties to be met with in practice, especially in operating, amongst the poorer classes. If you look into the above case you can imagine that the different anatomical points so elaborately set forth in the text books, etc., to be observed in operating on strangulated hernia are not easily to be found with your patient struggling and sitting up straight in bed and using all his muscles in fighting for breath.

Having come from a provincial hospital where for nearly two years I had been H.S. and H.P., I felt I could confidently tackle any such operation of the above nature, but one's ardour and confidence is greatly damped when operating under such conditions as reported above: at any rate, I shall ever have a bright and vivid recollection of my first "Hernia" in private practice.

ERNEST F. CLOWES,

Wotten-under-Edge.

Recent Additions to the Dental Museum.

Model of an acquired cleft palate caused by a dynamite explosion.—Mr. Morrell.

Model showing a well-marked cingulum of a right upper lateral.—Mr. Dawson.

The jaws of a dog-fish.—Mr. Maggs.

The jaws of a sargus.—Mr. Maggs.

Four models illustrating the jaws of a horse at different ages.—Mr. Maggs.

An upper model, showing a deciduous supernumerary tooth in the premaxilla.—Mr. Maggs.

A model showing the presence of three premolars on each side of the lower jaw.—Mr. Umney.

Models showing an open bite associated with a supernumerary tooth, an irregular central and stomatitic teeth.—Mr. Morrell.

An upper molar, with an enamel nodule situated between the buccal roots.—Mr. Wartski.

A bone upper denture which has been fitted with human teeth, and worn for a considerable time; several of the teeth are carious.—Mr. Wartski.

Model ilustrating the presence of a "blue line" on the gum arising from cleaning the teeth with soot.

A fibrous epulis connected with the periosteum of the left upper lateral and central.

Fœtal skull, fourth month.

J. L. P.

In Lighter Vein.

The dinner to Dr. Goodhart was great. An official description appears elsewhere in the paper, I doubt not, but that is my description. Everyone who was not there to see Dr. Goodhart go out in a blaze of Goodeyisms has my very sincere and heartfelt sympathy.

The *Daily News* is responsible for the following interesting, and possibly untrue, story of President Kruger:—

> "When a youth, Kruger was out hunting, and, being anxious to get a rhinoceros, loaded with more powder than usual, and fired.. The gun unfortunately burst and shattered the top joint of his thumb. . . He bound up his thumb as well as he could, but, unfortunately, it began festering and threatened to mortify, so that the worst must be feared. Whereupon, the youth, with amazing courage and incredible toughness, cut off the top joint of his thumb with his pocket knife. The evil had gone too far, and the operation was of no avail. Quite coolly, President Kruger then cut off the second joint, and the thumb then fortunately healed."

Had this event happened in later years, President Kruger would doubtless have called in Dr. Jameson. Presumably the Uitlanders are under the other thumb, but Oom Paul must beware of pressing too hard, or there will be more gangrene.

Brethren, we will burst into song:—

A LULLABY.

A mother in Victoria Ward croons to the newly-born.

Oh, hush thee, little baby mine,
Electric lights above thee shine,
And underneath thy cradle
An oil lamp burns to keep thee warm,
And sweet milk from the Aylesbury farm
Awaits thee in a ladle.

A nurse attends to all thy needs,
Awakening thee for hourly feeds;
Whilst I, thine anxious mater,
Can only sadly sit and sigh,
Because, unfortunately, I
Can't rock an incubator.

That tiny face beneath the glass,
A little while ago, alas,
Went very near to heaven;
For, little wilful infant mine,
Thou scorned'st the customary nine,
And murmured "We are seven."

So, if the water-bath run dry,
Or mercury should rise too high,
Thou wilt seek celestial strata.
But, anyhow, it seems all wrong
To sit and sing a cradle song
Outside an incubator.

DAILY HEALTH HINTS.

(With apologies to the *Daily Mail*).

Persons who desire to be healthy should eat a certain amount of food at meal times, and this may, with advantage, be supplemented with a little fluid nourishment. Pork eaten just before midnight is apt to cause indigestion and even dyspepsia. A hat should be worn in sunny weather, but an umbrella will be found useful in keeping off the rain. After getting wet through, always change your clothes, as dry garments will be found less damp than wet ones. A bath should be taken at least once a month; there is nothing to equal it as a cleansing agent. Soap may be used at discretion. A little alcohol taken internally acts as a stimulant, but too much alcohol is a frequent cause of drunkeness.—"Hygiene for the Hignorant."

I see by "The Broadway" that "The Medico" will appear next May; also that the editor of the well-known *Guyoscope* is devoting all his energies to it. The editor of the well-known *Guyoscope* tells me that for all the energy he is devoting to it, it will not be out till the May after next, for, as a matter of fact, he has nothing whatever to do with it. The Derby tips will be a trifle late at this rate.

A lady, who evidently knew her way about, recently entered the surgery and made straight for the bench on which patients await the H.-P. and H.-S. for the week. "Kindly go and sit over there," said the nurse, indicating the public benches; "who told you to sit there?" "What, aint this the diarrhœa and vomiting seat?" said the lady, rather hurt. "Well, this is where I've always sat before." Then they took her gently by the hand, and explained to her the error of her ways.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Medical Co-operation.

DEAR SIR,—May I, through your columns, draw the attention of any Guy's men practising, or thinking of practising in the North, to the advantages of becoming members of the Surgical Supply Association, Manchester.

Six of the seven directors, and all members, are qualified medical men, the chairman being an old Guy's man, Dr. T. G. Carr, of Manchester.

It is a purely mutual co-operative scheme set on foot at the end of 1897 by the medical profession, to supply themselves with every article necessary in practice from drugs, bottles, corks, and labels, to instruments, dressings, stationery, and bicycles, *at manufacturers' prices*. The intermediate profits thus saved to the impoverished G.P. are measurable only by the membership and patronage of the Association.

As I write this I have before me the balance sheet of a wealthy firm of druggists, who are paying a comfortable 10 per cent. on their ordinary shares, and I have no doubt the instrument makers are doing equally well. This is after deducting the expense of flooding the country with travellers in all directions.

At present 15s. per £1 share has been called up, and members are required to take five shares. Liability is, by the Memorandum and Articles of Association, limited to the amount of one's shares.

The immediate advantages of membership are :—

(1.) Trade discount as under for quarterly accounts. 12½ per cent. off Drugs (on Trade List about 5 per cent. below usual price). 10 per cent. off Instruments and Sundries. Universal bottles at cost price. All sizes of bottles are made with a uniform neck, so that only a single size of cork at 9d. per gross is necessary. The saving in a large practice should be very great. Here is an example from my own small concern. In Sept. last I ordered six gross 6 and 8 oz. bottles at 6s. 8d. per gross, which cost me with the crate (carriage paid) £2 1 0

Six gross of corks at 9d.	0	4	6
Total	£2	5	6

Under old conditions I should have had to pay six gross bottles at 9/- (including carriage)	£2	14	0
Carriage of returned empties (say)	0	1	6
Six gross corks at 1/3	0	7	6
Total	£3	3	0

or a saving of 27·7 per cent.

The saving of other items is equally satisfactory.

(2.) The great convenience of ordering *everything* from one address only, and receiving drugs and sundries in one parcel.

(3.) The great advantage of not being bothered with travellers, the employment of whom represents nearly twenty per cent. of the profits, and should be a great additional saving both of time and money. I am thankful to say I have not seen a single traveller since Christmas.

(4.) As the annual turn over increases the additional profits are to be divided amongst members as bonus *pro ratâ* to their purchases.

The membership has steadily increased from 60 at its formation to 436 at the present time.

If, as is suggested, carriage on drugs be paid by the Association, the principal objection to members at a considerable distance from Manchester joining, will have been removed.

As far as I personally am a judge of such matters, it seems to me an undertaking deserving the loyal support of every surgeon or G.P. within 150 miles of Manchester.

It is a purely mutual undertaking by the profession which is fleeced and taxed, defrauded and taken advantage of at least as much as any other profession, and ought, I think, to be classed along with such excellent institutions as the Medical Defence Union, and the Medical Sickness and Accident Society, to which every Guy's man in practice subscribes, or should subscribe, regularly as a matter of course.

My apology for the length of this letter is *pro bono medico*. I enclose copy of prospectus and directors' report for the year's working, which, with any further information can be obtained from the Secretary, Surgical Supply Association, 35, Market Street, Manchester,—Believe me, yours very truly,

Whitby A. J. SHARP.

British Medical Association.

429, STRAND, LONDON, W.C.

GRANTS FOR SCIENTIFIC RESEARCH.

THE Council of the British Medical Association desire to remind members of the profession engaged in researches for the advancement of medicine and the allied sciences that they are prepared to receive applications for grants in aid of such research. Applications for sums to be granted at the next annual meeting must include details of the precise character and objects of the research which is proposed and must be made on or before June 15th, in writing, addressed to the General Secretary, at the offices of the Association, 429, Strand, W.C.

Reports of work done by the assistance of Association grants belong to the Association.

RESEARCH SCHOLARSHIPS.

The Council of the British Medical Association are prepared to receive applications for one of the three Research Scholarships which is vacant, of the value of £150 per annum, tenable for one year, and subject to renewal by the Council for another year.

ERNEST HART MEMORIAL SCHOLARSHIP.

The Council are also prepared to receive applications for a Scholarship of £200 for the study of some subject in the department of State Medicine in memory of the late Mr. Ernest Hart.

Applications must be sent in writing on or before June 15th, stating the particulars of the intended research, qualifications and work done.

Forms of application for the Scholarships can be obtained from the General Secretary.

FRANCIS FOWKE,
429, Strand, London, General Secretary.
May 2nd, 1899.

Reviews.

Guide to the Clinical Examination and Treatment of Sick Children. By John Thompson, M.D., M.R.C.P. Lond. (Wm. F. Clay, Edinborough, 1898).

Medical Diseases of Infancy and Childhood. By Dawson Williams, M.D. Lond., F.R.C.P. (Cassell & Co., 1898).

In spite of the fact that students are continually told to study the diseases of childhood as so much of their future practice will be in that particular branch of medicine, the majority of men who leave a hospital are extremely ignorant of all that appertains to both the healthy and the diseased child.

Dr. Thompson's book on the clinical examination of children ought to be read by all senior students, although it does not profess to be more than an introduction to the investigation of the diseases of children. The first chapter on growth and development contains information which every qualified man ought to know and which few do, while in the third chapter the author dwells especially on the importance of physiognomical diagnosis, and illustrates the different facial aspects met clinically by some excellent photographs.

That most important part of the management of children, namely feeding, is treated at length, as are the disorders chiefly due to bad food. The book is full of particular "tips," and although not a substitute for such works as Goodhart's or Rotch's, yet it impresses on the reader one important fact, and that is that children when sick are very different to adults. The whole is well illustrated and there are some useful prescriptions in the appendix.

We confess we are somewhat disappointed with Dr. Williams' book. There is too much condensed general medicine, and too little of that which specially concerns children to make it popular with the average man. For instance, intussusception is treated as briefly as it is in the ordinary surgical text books, although the question of operation is one which is at present much debated. Some surgeons hold that a laparotomy is never justifiable in infants or very young children for this complaint, while others think that it might be done early if it is to be of any good. We should have liked Dr. Williams to give some more space to this important subject, as it is one on which anyone may have to give a definite opinion.

We are glad to see that overfeeding is given the chief place as a cause of dyspepsia, and the value of warm baths and alcohol in the treatment of broncho-pneumonia insisted on. The illustrations are good and numerous.

The Year Book of Treatment for 1899. This handy little volume consists as usual, in this its fifteenth appearance, of a compact yet complete summary of the progress made in medicine and surgery during the past year. The staff of contributors remains the same as last year, with the addition of Dr. Vincent Harris, who writes on Pulmonary Diseases. A new feature of this volume is an article on the Open-air Treatment of Phthisis, by Dr. Burton Fanning, illustrated by numerous photographs. Mr. Carless gives an excellent review of the General Surgery of the Year, perhaps the most valuable chapter in the book. We could have wished to see the names of our own staff more frequently as contributors to the literature of the year, the names Horrocks, Taylor, Lucas, Lane, and Fripp, alone appearing. Dr. Crosse's work on Black-water Fever does not pass unnoticed. Altogether, for the busy man—and who is not now-a-days?—this book is a *sine qua non* if he wishes to keep well up with the times. The printing is excellent and the price (5s.) moderate.

Messrs. CASSELL & COMPANY, LIMITED, announce the early publication of a new text-book on Orthopædic Surgery, by Mr. Jackson Clarke. The work is to consist of about 500 demy octavo pages, and will be fully illustrated. Besides furnishing a text-book on the subject it has been the author's aim to embody the many advances, including the Röntgen-ray process, that have been recently made in the department of surgery with which it deals. A special feature of the book is to be an exposition of the pathology of deformities as a basis of orthopædic surgery.

Manual of Surgical Treatment. By Cheyne and Burghard, in Six Parts. Part I. (Longmans, Green & Co.) 10s. 6d. per volume.

The first part of this work includes the treatment of General Surgical Diseases, including inflammation, suppuration, ulceration, gangrene, wounds and their complications, infective diseases and tumours. The administration of anæsthetics, by Dr. Silk.

The authors in the preface state that the want of detailed information, especially as regards the after-treatment of cases, has led to their setting forth at some length the details of those methods employed by them in their surgical practice. As so many methods of treatment may be employed for similar cases, they, fearing to be too long and tedious, restrict their discourse to one line of treatment, viz., that which in their experience they deem the best.

This, certainly, in many cases is all that is required, but some relaxation of that rule should have been made in favour of those maladies which are so numerous yet withal so varied that hardly two cases can be treated alike.

Take for instance the case of ulcers of the leg. Considering that the vast majority are of what the authors

call the "ambulatory" type, more information should have been given, and other lines of treatment suggested than simply Unna's bandage.

The giving of an anæsthetic in severe cases of burn is recommended, in order to thoroughly clean up not only the burnt area, but also the surrounding skin, and not, as used to be the case, applying burn dressing immediately to the septic wound. The giving of an anæsthetic, if the condition of the patient permits it, is a procedure which has been carried out at this hospital for some time and with marked success. Carron oil very rightly comes in for some abuse as a most noxious burn dressing.

The chapter on syphilis is well and fully written, attention being drawn to the expressed opinion of Continental writers against the use of mercury in the primary stage of syphilis on the ground of difficulty of certain diagnosis and the effect of the drug preventing its full use in the secondary stage if it has already depressed the patient during the primary.

The use of guiacol in tuberculosis is referred to favourably, and certainly we should like to know more of this drug, as its effects seem to be encouraging.

Mr. Edmund Owen receives the credit of a very old deceit practised on children, that of substituting cod liver oil for the usual sardine oil. The book is well printed and the illustrations numerous.

To the general practitioner, who has not had the benefit of a resident appointment at a large general hospital, the book will be of great value. On the other hand, there is very little suggested or recommended which has not been in daily use at Guy's for some time back.

Dr. Silk is responsible for the chapter on anæsthetics, which is in every way excellent. Local anæsthesia, by Dr. Schleich of Berlin's method of "Infiltration" is both explained and illustrated.

The Care of the Dying, price 6d. net, pp. 40; and *Some Thoughts about Nursing*, price 6d. net, pp. 30. By Oswald Browne, M.A., M.D. Cantab, F.R.C.P. (Published by George Allen.)

These are two short lectures delivered to nurses by the author. Both consist of somewhat jerky observations, interspersed with poetical quotations; and are upon such similar subjects that it would seem preferable to have both published in one pamphlet, price 6d. the two.

We feel sure that the exhortations of the first are needless; a woman's instinctive sympathy and tact will guide her actions by the death-bed better than any written advice. The second is perhaps more useful, pointing out the ways in which a nurse should exercise her powers of observation, thereby fitting her the better to assist the doctor whose directions she is carrying out, and whose treatment she is assisting by her most careful nursing.

Perhaps even ward clerks might benefit by glancing at the list of small points Dr. Browne enumerates, before passing on to Stage 2, Palpation.

Sport.

Cricket

GUY'S v. CROYDON.

This match was played on Wednesday, May 17th, at Croydon. Guy's won the toss and batted first on a very soft wicket. The bowlers appeared to have matters all their own way; however, we totalled 156, Trubshaw, Willan and Grellet doing best. We dismissed our opponents for 68, Bowle and Strange each taking three wickets for 12 and 7 runs respectively. Croydon followed on and made 124 for five wickets. Scores:—

GUY'S.

K. V. Trubshaw, b Neech	29
R. C. Poyser, b Archer	2
S. C. Boyle, b Neech	19
E. Graham-Smith, c sub., b West	3
H. M. Langdale, b West	10
W. A. Dennant, b West	2
G. T. Willan, b Neech	27
H. R. Grellet, b Neech	26
W. H. Bush, st Fifield, b Archer	9
E. W. Strange, b Archer	7
C. M. Cowper, not out	8
Extras	14
Total	156

CROYDON.

1st Innings.		2nd Innings.	
Rev. J. Sewell, c Grellet, b Bowle	7		
C. W. Feist, b Bowle	0	c Langdale, b Grellet	16
A. Lathom, c Langdale, b Bowle	19	st Graham-Smith, b Poyser	2
J. A. Archer, b Trubshaw	0		
J. C. Neech, c & b Trubshaw	1	not out	49
A. T. Smith, c Trubshaw, b Strange	11	not out	18
A. T. West, c Poyser, b Strange	8	st Graham-Smith, b Poyser	28
F. W. Fifield, b Cowper	2	c & b Poyser	8
W. Ashcroft, b Strange	0		
W. S. Jenner, not out	6	run out	0
Extras	14	Extras	3
Total	68	Total (5 wkts.)	124

GUY'S v. SURBITON.

This match was played on Saturday May 20th, at Surbiton. Guy's won the toss; Brydone was soon out, and then Graham-Smith and Poyser made a splendid stand, putting on 110 runs for the second wicket; Poyser was out lbw for 59. Graham-Smith went on and made his century, finally being caught for 110, which included 12 fours, a very fine innings. The wicket wore very badly, and except Trubshaw, no one else made double figures. As a late start had been made, our innings was declared closed for 198 for 8 wickets. The wicket was now rather treacherous, and by good fielding several very hot catches were held. We got rid of our opponents for 116 on the stroke of time. This was a very welcome victory, it being some years since we won at Surbiton. Trubshaw bowled best and took five wickets. Scores:—

GUY'S.

E. Graham-Smith, c Tireman, b Francis	110
J. M. Brydone, b Jupp	1
R. C. Poyser, lbw, b P. Castle	59
K. V. Trubshaw, b Windeler	10
S. C. Bowle, b Francis	6
H. M. Langdale, c Tireman, b Jupp	3
W. A. Dennant, not out	0
H. R. Grellet, b Jupp	6
E. W. Strange, b Jupp	0
C. M. Cowper, not out	0
L. Humphrey, did not bat	
Extras	3
*Total (8 wickets)	198

* Innings declared closed.

SURBITON.

S. S. Taylor, c Dennant, b Cowper	2
T. Castle, c Boyle, b Cowper	9
P. Castle, c Grellet, b Cowper	17
F. Francis, c Grellet, b Trubshaw	20
J. A. Hickson, c & b Trubshaw	1
C. B. Worsely, c Poyser, b Trubshaw	0
C. H. Jupp, c Grellet, b Poyser	37
W. B. Windeler, c & b Trubshaw	3
T. Tireman, c & b Trubshaw	4
C. Castle, c & b Bowle	11
Rev. A. E. Beavan, not out	2
Extras	10
Total	116

GUY'S v. BECKENHAM.

This match was played on Saturday, May 27th, at Beckenham. For the fourth time running Guy's won the toss and batted first; unfortunately several men had bad luck in getting out when apparently well set, and we only totalled 160, the scoring being very even. Our opponents had a very strong batting team, and we were very lucky to get six of them out for 120. After that they soon knocked the runs off, and gained a well-deserved victory by 131 runs. Our fielding was not all that could be desired, but mention must be made of two very fine catches by Langdale in the long field. Scores:—

GUY'S.

J. M. Brydone, c P. Baker, b Aste	14
E. Graham-Smith, c & b Williams	24
R. C. Poyser, b Aste	11
F. C. Wetherell, c Todd, b Williams	20
K. V. Trubshaw, lbw, b Williams	4
S. C. Bowle, b Stenning	11
H. M. Langdale, c H. Baker, b Aste	24
G. T. Willan, c Todd, b Aste	12
H. R. Grellet, b Pavri	8
C. M. Cowper, b Pavri	14
E. W. Strange, not out	0
Extras	18
Total	160

BECKENHAM.

F. D. Browne, c Langdale, b Wetherell	56
G. K. Stenning, run out	0
R. Williams, b Wetherell	61
M. Torrens, c Grellet, b Strange	4
J. H. Todd, c Langdale, b Wetherell	0
W. F. Noakes, run out	5
G. Gulliver, c Grellet, b Willan	81
H. E. Baker, b Cowper	0
M. E. Pavri, not out	26
P. C. Baker, c Trubshaw, b Cowper	38
J. Aste, c Boyle, b Trubshaw	8
Extras	12
Total	291

INTER-HOSPITAL CRICKET CUP DRAW.

Friday, May 19th.

A Westminster / Guy's

B St. Thomas's / Charing Cross

C Middlesex / King's College

D St. Bart's / St. Mary's

E London / University College

Ties A and B to be played on or before June 7th.

Guy's Hospital Lawn Tennis Club.

GUY'S v. BLACKHEATH.

This match had to be scratched on account of the wet weather.

GUY'S v. KENT.

At Honor Oak, Saturday, May 27th. Our First Six lost by 5 matches to 4, 13 sets to 11, 113 games to 95. Our opponents' first couple were a good deal too good for us, but all three couples should have beaten their second and third pairs. We were within an ace of winning when our first couple (in the ninth match, when the score of matches stood 4 all) were one set up, 5–4 and 40–15, they "cracked" badly and lost as below. Cross and Jupp showed great improvement, but our first and second pairs are not as good as they ought to be.

P. S. Mandy and H. K. Lacey lost to W. G. Grant Heelas and —. Hook, 0–6, 0–6; beat W. Dunn and R. F. Grant Heelas, 3–6, 7–5, 6–2; lost to W. T. Cousins and R. N. Dalgelish, 6–2, 6–8, 4–6. H. Wacher and L. Cooke beat Cousin and Dalgleish, 4–6, 8–6, 6–0; lost to Grant Heelas and Hook, 1–6, 2–6; beat Dunn and Grant Heelas, 6–4, 1–6, 6–4. F. G. Cross and E. N. Jupp lost to Dunn and Grant Heelas, 3–6, 6–2, 0–6; beat Cousins and Dalgleish, 4–6, 8–6, 6–0; lost to Grant Heelas and Hook, 4–6, 4–6.

GUY'S 2ND VI. v. ST. BARTHOLOMEW'S 2ND VI.

This match was played at Winchmore Hill on Saturday, May 27th, and resulted in our defeat by 5 matches to 4. Pye-Smith and Wedd, after losing their first round, won their other two somewhat easily. Our other two pairs could only succeed in winning one match each.

Team:—C. Pye-Smith and A. E. Wedd; E A. Ring and F. B. Manser; H. P. Wiltshire and J. Steele-Perkins.

2ND VI. v. ADDISCOMBE.

Two pairs went down to East Croydon on Wednesday, May 31st, to play the Addiscombe Club.

Owing to a late start it was agreed upon to play one round of singles and one round of doubles. In the singles Wedd and Steel-Perkins won their matches. In the doubles Guy's failed to secure a match, and so were defeated by four matches to two. Team:—C. D. Pye-Smith, A. E. Wedd. F. B. Manser, J. Steele-Perkins.

From the Gazette's Special Pathologist.

H. A. L., SWANSEA.—The tumour of the breast is a very soft spheroidal-celled carcinoma, and the axillary gland is filled with a similar growth.

H. G. A., NOTTINGHAM.—The tumour in the breast is a scirrhus carcinoma, invading the fat and the subjacent capsule of the gland. PATHOLOGIST.

Papers by Guy's Men.

A Systematic Bacteriological Examination of the Fauces in Scarlet Fever as a means of preventing Post-Scarlatinal Diphtheria. By G. C. Garrett, M.B. Cantab., and W. J. Washbourn, M.D. Lond. *British Medical Journal*, 15th April.

On Antistreptococcic Serum in the Treatment of Smallpox. By W. J. Lindsay, B.A., M.B., B.C. (with Charts) *British Medical Journal*. 13th May.

Cases of Gastroplasty and Pyloroplasty. By Thomas H. Morse, F R.C.S. Eng. *Lancet*, 13th May.

An Address on a Survey of the Climatic Health Resorts of the United Kingdom compared with those of the Continent. Delivered at a meeting of the British Balneological and Climatological Society, on April 27th, 1899, by Sir Hermann Weber, M.D. Bonn, F.R.C.P. Lond. *Lancet*, 20th May.

After-Progress and Treatment of Two Cases of Gastro-enterostomy. By Richard Bevan, L.R.C.P. Lond., M.R.C.S., D.P.H. *Ibid.*

Wound of the Right Ureter during Ovariotomy; Suture, Fistula, Recovery. By R. Lawford Knaggs, M.C. Cantab, F.R.C.S. Eng. *Ibid.*, 27th May.

On operations for Gastric Hæmorrhage and Perforation, with an account of a successful Operation for Perforating Gastric Ulcer. By A. H. Tubby, M.S. Lond., F.R.C.S. *British Medical Journal*, 27th May.

Appointments.

CIVIL.

ASHWIN, R. HAMILTON, M.B. Lond., L.R.C.P., M.R.C.S., has been appointed Medical Officer for the Second Market Weighton District of the Pocklington Union.

BYFORD, W. F., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer for the No. 1 Sanitary District of the Ruthin Union, *vice* D. W. Jones, resigned.

DENYER, STANLEY E., M.A., M.B., B.C. Cantab., L.R.C.P. Lond., M.R.C.S., has been appointed House-Surgeon to the Royal Free Hospital, Gray's Inn Road, W.C.

FEATHERSTONE, G. W. B., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer for the Radnorshire Sanitary District of the Hay Union.

GOLDING-BIRD, C. H., F.R.C.S, has been appointed an Examiner in Surgery for the University of Cambridge.

LOUD, L.R C.P. Lond, M.R.C.S., has been appointed Medical Officer for the Fifth District of the Lewes Union.

MATHIAS, RICHARD, M.A., M.B., B.C. Cantab., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer for the Pentyrch District by the Cardiff Board of Guardians.

PERKINS, H. BOWEN, L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer for the Barking District of the Romford Union.

PRICE, JOHN A. P., B.A. Oxon., M.D. Lond., has been appointed Surgeon to the Royal Berks Hospital, Reading.

NAVAL AND MILITARY.

Surgeon WALTER J. BEARBLOCK is appointed to the *Cambridge*, and Surgeon GEORGE E. DUNCAN to the *Renown*.

Lieut.-Colonel W. A. MAY, R.A.M.C., is posted to the Cork District.

Surgeon-Lieutenant HENRY FULTON, 1st Hants Volunteer Corps, resigns his commission, and is appointed Second Lieutenant (Supernumerary).

The following gentlemen have been granted commissions as Surgeons in the Royal Navy, and are appointed to the *Duke of Wellington*, additional for Haslar Hospital: C. R. NICHOLSON, J. T. M. MCDOUGALL, A. W. NOURSE, J. H. JONES, J. E. POWELL.

Captain STATHAM, A.M.C., has been detailed for Plague duty.

The services of Lieut.-Colonel J. S. WILKINS, D.S.O., I.M.S., are replaced at the disposal of the Government of India from May 1st, 1899, on relinquishing charge of the duties of Special Medical Officer for Plague Operations, Bombay.

Births.

STEAD.—On May 9th, at Moor Lodge, Hawkhurst, Kent, the wife of Dr. C. C. Stead, of a daughter.

THOMSON.—On May 13th, at 243, Queen's Road, New Cross Gate, S.E., the wife of David Thomson, L.R.C.P., L.R.C.S. Edin., L.F.P.S. Glasg., of a daughter.

WILSON-SMITH.—On May 19th, at Brock Street, Bath, the wife of T. Wilson Smith, M.D. Lond., of a daughter.

ED.—H. L. E.

Contents.

	PAGE
APPENDICITIS: NOT A NOVELTY. By Sir Samuel Wilks, Bart., LL.D., F.R.S.	241–242
PROGNOSIS IN RECTAL CANCER: Clinical Lecture by Mr. Symonds	242–247
GUY'S HOSPITAL DENTAL SOCIETY	247
HOSPITAL NEWS	247–249
PAPERS BY GUY'S MEN	249
NURSING NOTES	250
ROYAL COLLEGE OF SURGEONS OF ENGLAND	250
NOTICE	250
FROM THE GAZETTE'S SPECIAL PATHOLOGIST	250
PASSIM	251–252
OBITUARY: Leonard Slater	252
THE BATTLE OF THE STRONG	253
REVIEWS	253
A CASE OF CEREBRAL HÆMORRHAGE COMPLICATED BY A SUB-HYALOID (RETINAL) HÆMORRHAGE	254
TRANSFUSION	256–257
IN LIGHTER VEIN	257–258
NURSING NEWS	258
SPORT: Cricket—Guy's v. Reigate Priory; Guy's v. Westminster—Inter-Hospital Cup Tie; Guy's v. Ashbv-de-la-Zouch. Guy's Hospital Chess Club. Guy's Hospital Lawn Tennis Club—Guy's v. Harold; Guy's v. Hornsey; Guy's v. Redhill; Guy's 2nd v. Gipseys' 2nd	258–260
APPOINTMENTS	260

Calendar of Coming Events.

June, 1899.

Sat. 17.—Messrs. Lucas and Lane's take-in; Drs., J. S. S. Perkins and J. C. J. Da Silva; Cl., G. N. Meachen.
G.H.C.C., I., Past v. Present, 11 a.m., home.
II., Clapham United, 2.30 p.m., away.
G.H.L.T.C., Past v. Present, home.
G.H.B.C., Golding-Bird Cup Race, Sheen House.
Hos.-Scho. C.C., St. George's, Brockley.

Tues. 20.—12 noon, Mr. Rowell's Demonstration on Anæsthetics,

Wed. 21.—1 p.m., Clinical lecture by Dr. Washbourn.
Guy's Hospital Athletic Sports, 2.30 p.m.
G.H.C.C., II., Dental Hospital, home.
G.H.L.T.C., Connaught, away.
G.H.B.C., U.H.B.C. v. Dublin U.B.C., Dublin.

Thur. 22.—Messrs. Golding-Bird and Dunn's take-in; Drs., E. J. F. Hardenberg and T. R. Beale-Browne; Cl., D. J. Munro.
G.H.M.P.U., Missionary Meeting.
G.H.S.C., Grafton, home.

Fri. 23.—1 p.m., Clinical lecture by Mr. Lane.

Sat. 24.—G.H.C.C., I., Eastbourne, away.
II., St. Mark's College, home.
G.H.L.T.C., Chiswick Park, away.
G.H.B.C., U.H.B.C. v. Oxford U.B.C., Sheen House.
Hos.-Scho. C.C., Hanover, home.

Mon. 26.—G.H.S.C., Ravensbourne, home.

Wed. 28.—1 p.m., Clinical lecture by Dr. Washbourn.
G.H.C.C., II., St. Bart's, away.
G.H.L.T.C., The Staff, home.

Thur. 29.—Messrs. Howse and Jacobson's take-in; Drs., J. E. L. Bates and W. P. Ker; Cl., F. D. Turner.
Second Conjoint exam. begins.
G.H.M.P.U., Address by Rev. A. E. Barnes-Lawrence.
G.H.B.C., U.H.B.C. v. Cambridge, Sheen House.

Fri. 30.—1 p.m., Clinical lecture by Mr. Lane.
G.H.B.C., London Scottish, away.

July.

Sat. 1.—October Appointment List opens.
G.H.C.C., I., Reigate Priory, home.
II., New Lyric, away.
G.H.B.C., Run to Hatfield.
G.H.L.T.C., Chiswick Park, Chiswick.
Hos.-Scho. C.C., Wandsworth Prison Officers, home.

Guy's Hospital Gazette.

JUNE 17, 1899.

Appendicitis: Not a Novelty.

BY SIR SAMUEL WILKS, Bart. LL.D., F.R.S.

THERE is a tendency as we advance in years to look back at the knowledge we possessed in our younger years as perfect, and to regard with scepticism the novelties of modern days. I am quite aware of the everyday exclamation of the older men in the profession, when hearing any medical subject discussed, "We knew all this in our younger days." Whilst alive to this possible weakness of age, I confess to a feeling of jealousy of the fame of Guy's when the subject of Appendicitis is so often put before us as a novel disease in our pathology. There is really nothing new in it but the name.

Most of the older works on medicine give a description of typhlitis and perityphlitis, or inflammation of the cæcum; to this is added an account of perforation of the vermiform process and its acting as a snare to catch cherry-stones and date-stones.

Now, my own knowledge of typhlitis from my earliest acquaintance with Guy's Hospital was that it was due to a primary disease of the vermiform process or appendix cæci. This is what Addison taught and what I confirmed by post-mortem examination.

Bright and Addison, it may be remembered, commenced the publication of a work on medicine, but only one volume appeared, which was wholly written by Addison. This was published in 1836, sixty-three years ago, and before the majority of those now practising medicine were born. He wrote as follows: "The portion of the intestine which is lodged in the right iliac region is frequently the

seat of inflammation. A hardness and tumefaction are soon evident, and this continuing general symptoms of peritonitis often take place and terminate fatally; or the inflammation may remain circumscribed and assume the form of deep-seated abscess. This may open of its own accord and ill-conditioned pus escape, which from its smell is soon discovered to be mixed with feculent matter. From numerous dissections it is found that the fæcal abscess thus formed arises in a large majority of cases from disease set up in the appendix cæci. This organ is very subject to inflammation, ulceration, and gangrene, or may become thickened and ulcerated from tuberculous deposit. This worm-like process is often detected in the midst of the abscess with a perforation at its extremity. Foreign bodies may have fallen in and irritated it, but one of the most common causes is the formation of a peculiar concretion moulded in the canal and composed of layers of earthy phosphates with occasional portions of feculent matter."

It seems to have taken the profession a great many years to recognise these facts so clearly laid down by Addison. What is new has reference to the treatment by operation before any abscess is apparent. It is this which has brought the disease so prominently before our notice. Indeed, it has become a fashionable operation. In reference to this there is a story now current of a man who is occasionally seized with violent attacks of colic, probably due to some band of adhesion, and at these times he is too ill to give a clear account of his case, so he has had written on his abdomen in indelible ink, "Please don't operate, I have had my appendix removed three times." I am told that the disease and the operation are becoming fashionable in Paris amongst ladies. This is remarkable, seeing that in England the disease is comparatively rare in the female sex. When I lectured I knew the exact majority of boys over girls, but this has now passed from my memory. It is essentially a complaint of the youthful male. This must be due to some anatomical cause which is not apparent.

This suggestion may remind the readers of Tristram Shandy of the following dialogue:—"I beseech you, Dr. Slop," quoth my Uncle Toby, interrupting him as he mentioned the *blind gut*, in a discourse with my father, the night my mother was brought to bed of me. "I beseech you," quoth my Uncle Toby, "to tell me which is the blind gut, for, old as I am, I vow I do not know to this day where it lies."

"The *blind gut*," answered Dr. Slop, "lies betwixt the ilion and colon."

"In a man?" said my father.

"'Tis precisely the same," cried Dr. Slop, "in a woman."

"That's more than I know," quoth my father.

Prognosis in Rectal Cancer.

CLINICAL LECTURE BY Mr. SYMONDS.

June 2nd, 1899.

Gentlemen,—I propose to ask your attention to some points in the Prognosis of Cancer of the Rectum. I have some material which I think may be useful in demonstrating the principal points to be considered in the prognosis of this particular class of cancer. In order that you may yourselves be able to form a prognosis on some accurate basis, I will show you three specimens. This first shows that in one form the disease goes completely round the bowel, forming a stricture. In this specimen so narrow is the stricture that it will not even admit a No. 3 catheter. There is a very small amount of growth here; in fact, at first sight, it would be difficult to say that it is cancer of the bowel, and yet it is a malignant stricture of the rectum. In this form of cancer of the rectum the disease is limited, only a small part, say half an inch of the bowel being involved; but as the disease grows it tends to cicatrize and pucker the wall of the bowel, and that puckering (better exhibited in this specimen) tends to give rise to all the symptoms of stricture. Well, then, in looking at this specimen, you would almost at once say that the principal symptoms from which this patient suffered would be constipation, leading on subsequently to obstruction of the bowels.

Of another form of cancer of the rectum we have this excellent specimen (shown), in which the main characteristics are that the growth is abundant, and that it projects in large masses into the lumen of the bowel. In this way you may have a cancer of the rectum which grows into the bowel, fills the lumen, and thereby causes an obstruction, entirely different from that caused by the first specimen I spoke of. In this specimen the surface is, as you see, very extensively ulcerated, but there is no attempt whatever at contraction of the wall of the bowel. So that here we get the opposite extreme; the growth is soft, rapidly degenerates and bleeds, and perforates through the wall into the neighbouring structure. In the first case you have a limited disease which gives

rise to obstruction; whereas, in this second form the cancer produces obstruction by the large amount of its growth, and is more likely to perforate through the bowel and penetrate into adjoining cavities, such as the bladder, the urethra in men, or the vagina in women. Well, that will help us very much in the prognosis of these cases.

There is a third arrangement of growth, a further way in which cancer in the bowel disposes itself. We have not a good specimen of this. It is a form in which the disease is an ulcer with raised edges and a depressed surface. Suppose this (drawn on blackboard) to be the rectum, we have an ulcerated growth with hard edges, and a depressed surface on some part of the bowel; so that you would not have so much bleeding and discharge of mucus as in the soft and rapidly growing variety, but simply the signs of rectal irritation, a little blood and mucus, and frequent action of the bowels, meaning simply discharge from the rectum and not diarrhœa.

These specimens might be taken as the three types of carcinoma of the bowel.

Now I want just to ask your attention to the more important points concerning the prognosis of cancer of the rectum, because that is a subject on which, in the course of practice, you will be questioned in many cases.

Let us, first of all, say that we have a case of cancer of the rectum to deal with of the constricting variety. What is the prognosis in such a case? We have seen that the one symptom to which it will give rise is obstruction. Well, then, if such a case be left alone, what will be its probable course? You would tell the patient that in the course of time the opening will get smaller, that obstruction of the bowel will occur, and that, unless relieved, the patient will die from vomiting and intestinal obstruction; but if relieved by colotomy, life will be prolonged. Occasionally these patients will get on very well without colotomy; I have known one live for five years with stricture of the rectum due to malignant disease. If colotomised, we should expect these patients to live from two to five years, the greater part of that time with the colotomy wound established. You may fairly say, then, that if the patient declines the operation, obstruction will be the chief complication. You are not likely to get perforation of the bowel near the stricture, the disease not being of the kind which ulcerates. If the obstruction be prolonged and the distension extreme, there may be stercoral ulceration of the cæcum and perforation. So that you form your prognosis, first, upon the limited character of the disease, secondly, upon its tendency to constrict, and its little liability to give rise to secondary deposits in other parts of the body.

Next, as to the prognosis in the rapid varieties, where the growth extends round the bowel, and gives rise to a great deal of ulceration. In all these the course of duration is very much shorter. Taking cancer of the rectum as a whole, these softer varieties would be those that bring the average down to a short period. In these rectal cases the duration of life, as we have seen, runs between one and a half to about five years, but the majority of them die within three years certainly. Well, then, if you have a soft variety on which to form a prognosis, and the patient should ask you, "If I leave this alone what will happen?" you would say it will very likely spread into the bladder, or vagina, or the peritoneal tissues, and give rise to fistula and so to a great deal of pain and distress.

The next point in making a prognosis of these cases is this. In all varieties, but especially in the soft varieties, there is another danger, and that is, the danger of metastasis, a deposit of the growth in other parts of the body, notably in the liver. Now, it is very difficult to forecast this complication; indeed one must leave it as an unknown factor, at any rate in its early stage, and therefore a metastatic deposit in the liver or in the peritoneum may throw the whole of your calculations entirely out. I have had a case of cancer of the rectum this very morning, and so far as we can estimate the case, there are no secondary deposits; but there is the unknown factor that at present there may be a metastatic deposit. So do not forget that; and I think it will save you disappointment. In the soft varieties, then, you must think that the patient may have some perforation, incontinence of fæces, and all those symptoms which may be relieved by colotomy; and in giving a prognosis you must tell the patient that he is liable to all these things, but that colotomy will relieve him and also prolong his life.

Another important point about cancer of the rectum is, that it is a disease which occurs very early in life. About the age of forty it is not at all uncommon. I have had cases at sixteen, nineteen, twenty-eight.

Again: In giving a prognosis you should remember that cancer of the rectum is slow in growth as compared, for instance, with cancer of the tonsil, or tongue, or pharynx.

There is another very interesting point with regard to cancer of the rectum. It does not

infect the lymphatic glands with the same rapidity as cancer of the tongue, or tonsil, or pharynx. That is another reason for saying that the disease will probably be slow; it is also an excellent reason for advising an operation. But against these advantages we must set the fact that the glandular area is not so accessible as in the neck or axilla.

Now let us go back for a moment to the question of secondary deposits. In what proportion of cases does a secondary deposit arise? Well, we have not a very good list of cases to go upon, but there is one quoted by Mr. Cheyne. Forty-seven patients were examined who died of cancer of the rectum of long standing, and of these he found twenty-one with secondary deposits; so that you see secondary deposits may occur in considerably more than fifty per cent. of the cases. It is not stated how long these cases had existed, therefore the information is not very accurate. In fact it is very difficult indeed to say, when you get a *post-mortem*, how long cancer of the rectum has existed, or to estimate the length of its duration when you have the patient clinically before you. Therefore in forcasting the future of the patient, you must very carefully take into consideration the duration of the patient's symptoms as an estimate of the time the disease will last. But you must also consider the amount of the disease, its fixity, and other signs indicating its duration. If a patient, for example, gives a history of three months, you would add on another six or twelve months; if a growth has found its way to the bladder or vagina, from the rectum, but has a short history, you would be obliged to add on again a considerable number of months to that history.

Another point in regard to the value of the patient's history in making a prognosis. Rectal cancer is a disease which gives comparatively little pain. When you see this disease in the rectum, you think it must be a very painful affection. To say that cancer of the rectum is painless would not be quite true, but what strikes me regarding it is this, the number of cases which come before us, with extensive malignant disease of the rectum, with no history of pain whatever. Cancer of the rectum is almost a painless disease, until it either extends to the sphincter ani, or to some nervous structure, such as you find about the sacrum, or to some cavity such as the bladder. I remember a patient coming into the medical wards with an enormous liver, but complaining of nothing whatever except weakness. In that case we found a large cancerous liver, and on examining the rectum we found cancer, of which the patient made no complaint at all. So that carcinoma of the rectum is not a very painful disease. I think you must bear that in mind. It is, in my view, more important for you to remember that fact in making a diagnosis than it is in forming a prognosis. Patients with disease of the rectum sometimes come and tell you they have got piles, and their word is taken, the rectum is not examined, and an early cancer is overlooked. So you must remember that cancer of the rectum is painless in its early stages, and you must examine the rectum to make anything like a proper diagnosis, which, of course, will direct the prognosis of the cases.

Reverting once more to the subject of metastasis, how apt we are to be caught by this unknown factor! A short time ago I saw a lady of sixty-five, an active little woman, with cancer of the rectum, one of the softer varieties, showing considerable ulceration, and with some projecting growths upon it. She had had it about six months, and one thought there was no danger of obstruction of the bowel, and no immediate necessity for colotomy. I thought this might come on later, but that she might very safely go for another nine or twelve months without colotomy, certainly without any danger to life. I saw her again a month afterwards, and she then complained somewhat of abdominal uneasiness. I examined her abdomen and found nothing whatever. But within three months she was very ill indeed, and Dr. Davy, of Exeter, then found that she was suffering from an enlarged liver: and she was dead within another month. So that although I thought, from the history she gave me of the extent of the disease, that she might live a year, she died within a few months of secondary deposit in the liver. It was rather a tragic case, because her son was in India, and she wanted to know if he should come home immediately. I said I did not think it was necessary then, because he was due to come home in February, and we were then in the month of August, I think; but as it turned out she was dead before Christmas. That is just one of the common things which occur in ordinary practice. How important, then, it is to forecast, as far as you can, the future of these cases!

I remember another striking example of a woman in this hospital who died of tumour of the brain. When she died Dr. Fagge made a post-mortem and found localised epithelioma in the brain. Now, it must have had some primary origin. The body was examined for primary growth without its being found, but

Dr. Fagge was not likely to leave anything undone in that direction, and so he had the body re-opened and found he had left a little piece of the rectum behind, about two inches, and in this portion of the rectum a primary epithelioma was found. That is an example of the extreme danger of metastasis. Although the growth in the rectum was discovered to be quite small, it had infiltrated the surrounding parts, and, from some accidental arrangement in connection with the vascular system, had been absorbed into the brain and caused early death without any symptoms pointing to the rectum.

Another instance came to me in 1895, a man of thirty-four who had cancer of the rectum. It was of a hard type, with raised margins. He came in on September 3rd. The disease was easily reached with the finger; it was movable, it was not adherent to the surrounding structures, and it was a typical example for operation, and we operated on September 7th. I adopted the plan of ligaturing the bowel and bringing it out through the back to prevent infection of the wound, and I thought by doing this that I would prevent septic trouble. This ligature held for five days, and everything seemed to promise very well indeed. But within a week the man showed temperature ranging between 99° and 101°. In about three weeks' time he had a temperature of 102° or 103°, and exhibited all the signs of a man dying of septicæmia following operation. One was disappointed to think we had not surgically been able to prevent this complication. He died on October 22nd, so that he lived six weeks after being operated upon. After he died we found that the wound in the pelvis had healed very nicely, and there was no sign of any growth having been left. But there were some secondary deposits in the glands along the aorta, the mediastinal and mesenteric glands were infected, and the liver was studded with secondary nodules of growth. There was no pyæmia, the temperature being due to the disseminated cancer. Unoperated upon, we would have given that man only twelve months to live; operated upon, one thought it possible to add several years to his existence. You see, therefore, two leading points come out in this case. First, that it is impossible to estimate the amount of glandular infection in giving a prognosis. Here we had glandular infection far beyond the reach of the finger. Secondly, that it is impossible to estimate as to secondary growths; they were present in this man although there was no enlargement of the liver when examined; so that those are things which you must take carefully into consideration in forming a prognosis in these cases.

Is there anything that will help us to a recognition of the metastatic deposits in these cases, apart from the touch? The only thing one can say in answer to that is this: that the patient who has lost weight should be viewed with a great deal of suspicion, and also the patient who is anæmic. That old lady, for instance, whom I mentioned, had somewhat failing health, with loss of appetite, but there was no obvious reason for these symptoms beyond a moderate obstruction. However, she was very unhappy, and complained that she could not eat this and that. Now there is no doubt, I think, that in these cases of metastatic deposits, symptoms of this kind are of very great importance, but I missed them in estimating her case; I did not give to them their full significance. So that my error, I hope, will help to correct any like error which you might make. One is too apt to look upon the patient as fidgety.

Now let us take one or two cases in which the opposite result has happened. I operated some six months since upon a man for complete obstruction. Examination per rectum revealed a large mass filling the pelvis, and from its hardness there seemed no doubt that it was cancer of the rectum. I performed inguinal colotomy and again recognised a large nodular mass in the pelvis, to which hard mass the small intestine was adherent, as frequently does happen, and there seemed no doubt as to the nature of the case. Instead of picking up rapidly, as one expected, the man got very low and looked as if he were going to die. He became very thin and feverish, and for the time being I could give no explanation of this, except that there might be disseminated disease from metastatic deposits. I heard nothing more about the man except that he recovered, and so rapidly, that within three months he reported himself as perfectly well, and able to resume his duties as manager of a bank. His medical man wrote to me saying he had examined him and found no disease whatever about him, and that the colotomy wound had closed. As the case was such an extraordinary one, I asked to see the man, and on examining him per rectum, as high up as possible, I could feel a little uncertain induration only, but the huge mass in the pelvis had entirely disappeared.

What was the matter with this man? I presume he had an ulceration of his rectum, with perforation, and cellulitis around the bowel, such as occurs sometimes in women after

infect the lymphatic glands with the same rapidity as cancer of the tongue, or tonsil, or pharynx. That is another reason for saying that the disease will probably be slow; it is also an excellent reason for advising an operation. But against these advantages we must set the fact that the glandular area is not so accessible as in the neck or axilla.

Now let us go back for a moment to the question of secondary deposits. In what proportion of cases does a secondary deposit arise? Well, we have not a very good list of cases to go upon, but there is one quoted by Mr. Cheyne. Forty-seven patients were examined who died of cancer of the rectum of long standing, and of these he found twenty-one with secondary deposits; so that you see secondary deposits may occur in considerably more than fifty per cent. of the cases. It is not stated how long these cases had existed, therefore the information is not very accurate. In fact it is very difficult indeed to say, when you get a *post-mortem*, how long cancer of the rectum has existed, or to estimate the length of its duration when you have the patient clinically before you. Therefore in forcasting the future of the patient, you must very carefully take into consideration the duration of the patient's symptoms as an estimate of the time the disease will last. But you must also consider the amount of the disease, its fixity, and other signs indicating its duration. If a patient, for example, gives a history of three months, you would add on another six or twelve months; if a growth has found its way to the bladder or vagina, from the rectum, but has a short history, you would be obliged to add on again a considerable nnmber of months to that history.

Another point in regard to the value of the patient's history in making a prognosis. Rectal cancer is a disease which gives comparatively little pain. When you see this disease in the rectum, you think it must be a very painful affection. To say that cancer of the rectum is painless would not be quite true, but what strikes me regarding it is this, the number of cases which come before us, with extensive malignant disease of the rectum, with no history of pain whatever. Cancer of the rectum is almost a painless disease, until it either extends to the sphincter ani, or to some nervous structure, such as you find about the sacrum, or to some cavity such as the bladder. I remember a patient coming into the medical wards with an enormous liver, but complaining of nothing whatever except weakness. In that case we found a large cancerous liver, and on examining the rectum we found cancer, of which the patient made no complaint at all. So that carcinoma of the rectum is not a very painful disease. I think you must bear that in mind. It is, in my view, more important for you to remember that fact in making a diagnosis than it is in forming a prognosis. Patients with disease of the rectum sometimes come and tell you they have got piles, and their word is taken, the rectum is not examined, and an early cancer is overlooked. So you must remember that cancer of the rectum is painless in its early stages, and you must examine the rectum to make anything like a proper diagnosis, which, of course, will direct the prognosis of the cases.

Reverting once more to the subject of metastasis, how apt we are to be caught by this unknown factor! A short time ago I saw a lady of sixty-five, an active little woman, with cancer of the rectum, one of the softer varieties, showing considerable ulceration, and with some projecting growths upon it. She had had it about six months, and one thought there was no danger of obstruction of the bowel, and no immediate necessity for colotomy. I thought this might come on later, but that she might very safely go for another nine or twelve months without colotomy, certainly without any danger to life. I saw her again a month afterwards, and she then complained somewhat of abdominal uneasiness. I examined her abdomen and found nothing whatever. But within three months she was very ill indeed, and Dr. Davy, of Exeter, then found that she was suffering from an enlarged liver: and she was dead within another month. So that although I thought, from the history she gave me of the extent of the disease, that she might live a year, she died within a few months of secondary deposit in the liver. It was rather a tragic case, because her son was in India, and she wanted to know if he should come home immediately. I said I did not think it was necessary then, because he was due to come home in February, and we were then in the month of August, I think; but as it turned out she was dead before Christmas. That is just one of the common things which occur in ordinary practice. How important, then, it is to forecast, as far as you can, the future of these cases!

I remember another striking example of a woman in this hospital who died of tumour of the brain. When she died Dr. Fagge made a post-mortem and found localised epithelioma in the brain. Now, it must have had some primary origin. The body was examined for primary growth without its being found, but

Dr. Fagge was not likely to leave anything undone in that direction, and so he had the body re-opened and found he had left a little piece of the rectum behind, about two inches, and in this portion of the rectum a primary epithelioma was found. That is an example of the extreme danger of metastasis. Although the growth in the rectum was discovered to be quite small, it had infiltrated the surrounding parts, and, from some accidental arrangement in connection with the vascular system, had been absorbed into the brain and caused early death without any symptoms pointing to the rectum.

Another instance came to me in 1895, a man of thirty-four who had cancer of the rectum. It was of a hard type, with raised margins. He came in on September 3rd. The disease was easily reached with the finger; it was movable, it was not adherent to the surrounding structures, and it was a typical example for operation, and we operated on September 7th. I adopted the plan of ligaturing the bowel and bringing it out through the back to prevent infection of the wound, and I thought by doing this that I would prevent septic trouble. This ligature held for five days, and everything seemed to promise very well indeed. But within a week the man showed temperature ranging between 99° and 101°. In about three weeks' time he had a temperature of 102° or 103°, and exhibited all the signs of a man dying of septicæmia following operation. One was disappointed to think we had not surgically been able to prevent this complication. He died on October 22nd, so that he lived six weeks after being operated upon. After he died we found that the wound in the pelvis had healed very nicely, and there was no sign of any growth having been left. But there were some secondary deposits in the glands along the aorta, the mediastinal and mesenteric glands were infected, and the liver was studded with secondary nodules of growth. There was no pyæmia, the temperature being due to the disseminated cancer. Unoperated upon, we would have given that man only twelve months to live; operated upon, one thought it possible to add several years to his existence. You see, therefore, two leading points come out in this case. First, that it is impossible to estimate the amount of glandular infection in giving a prognosis. Here we had glandular infection far beyond the reach of the finger. Secondly, that it is impossible to estimate as to secondary growths; they were present in this man although there was no enlargement of the liver when examined; so that those are things which you must take carefully into consideration in forming a prognosis in these cases.

Is there anything that will help us to a recognition of the metastatic deposits in these cases, apart from the touch? The only thing one can say in answer to that is this: that the patient who has lost weight should be viewed with a great deal of suspicion, and also the patient who is anæmic. That old lady, for instance, whom I mentioned, had somewhat failing health, with loss of appetite, but there was no obvious reason for these symptoms beyond a moderate obstruction. However, she was very unhappy, and complained that she could not eat this and that. Now there is no doubt, I think, that in these cases of metastatic deposits, symptoms of this kind are of very great importance, but I missed them in estimating her case; I did not give to them their full significance. So that my error, I hope, will help to correct any like error which you might make. One is too apt to look upon the patient as fidgety.

Now let us take one or two cases in which the opposite result has happened. I operated some six months since upon a man for complete obstruction. Examination per rectum revealed a large mass filling the pelvis, and from its hardness there seemed no doubt that it was cancer of the rectum. I performed inguinal colotomy and again recognised a large nodular mass in the pelvis, to which hard mass the small intestine was adherent, as frequently does happen, and there seemed no doubt as to the nature of the case. Instead of picking up rapidly, as one expected, the man got very low and looked as if he were going to die. He became very thin and feverish, and for the time being I could give no explanation of this, except that there might be disseminated disease from metastatic deposits. I heard nothing more about the man except that he recovered, and so rapidly, that within three months he reported himself as perfectly well, and able to resume his duties as manager of a bank. His medical man wrote to me saying he had examined him and found no disease whatever about him, and that the colotomy wound had closed. As the case was such an extraordinary one, I asked to see the man, and on examining him per rectum, as high up as possible, I could feel a little uncertain induration only, but the huge mass in the pelvis had entirely disappeared.

What was the matter with this man? I presume he had an ulceration of his rectum, with perforation, and cellulitis around the bowel, such as occurs sometimes in women after

parturition; and that as soon as I colotomised him, he began to absorb this swelling, which process of absorption accounted for the depression in health which continued for three weeks after the operation. That is my explanation of this very remarkable case, but I am watching him still, fearing the development of cancer.

I saw another man not very long ago, with hæmorrhage in the bowel, and with all the signs of ulceration and cancer. We could feel a distinct lump on examination. This is about four years ago, and now that man is perfectly well and has no symptom in the rectum at all; so that his lump also which looked very suspicious indeed—and we gave a very guarded prognosis in regard to his case—has disappeared. In the case of the bank manager the prognosis was that he would probably not be able to do any further work, and that I did not think he would live twelve months. He was advised to give up his work at once and retire. Here was an example of a prognosis which was entirely wrong. I hope his friends are as pleased as I am, but I am afraid they are a little sceptical about my knowledge, because I gave this prognosis.

My reason for still being anxious as to this patient's future is the fact that we do get small malignant ulcers in the bowel, giving rise to large cellulitic formations indistinguishable from simple cases throughout. There is in the museum an epithelioma of the cæcum an inch in diameter, which gave rise to a large swelling in the patient's iliac fossa. This suppurated and healed up. I was asked to divide the tendon of the sartorius, as it was thought its contraction as a result of the suppuration determined flexion of the hip. However, on examination I found the iliac fossa full of solid growth, and other evidence of cancer of the cæcum. So that you may get a minor primary swelling of this kind giving rise to an extensive secondary swelling, and in bowel cancer recollect that perforation may cause much periproctitis.

Then once more. You have to give a prognosis as to how long a patient may live, and he may ask you, "Shall I live any longer if colotomy is performed?" No doubt patients do live a little longer with colotomy. If you have a case of cancer of the rectum, with no obstruction, not much pain, and no fistula, it is just a question whether you should advise colotomy with a view of prolonging life. You must, first, be able to answer the question as to how much you are going to prolong life in such a case. My own opinion about that is, not to advise colotomy as long as the patient keeps fairly comfortable. The few days or weeks of life that may be purchased by colotomy are rather dearly purchased at the price of the colotomy wound. Therefore, I would not do colotomy with a view of prolonging life, but with a view of making life comfortable, and of saving life, as in a case of obstruction.

With regard to the cases that have been colotomised, the statistics show that most of the patients die within the first or second years after the operation. Of course, some of them will live much longer, even for five years. Mr. Watson-Cheyne gives a history of one patient who lived for five years after colotomy.

Another question. If we put colotomy aside, and we have a case which is suitable for an excision of the rectum, will life be prolonged if the growth be excised? That is another question we shall have to make a prognosis upon in practice. Well, it is difficult at the present time to give a very good answer to that question, because the numbers of cases are not quite sufficient to guide us to a proper judgment in the matter, and because the results vary so much under different operators. But statistics have been furnished by two or three authorities and it appears to be pretty certain that the mortality after excision by the perineum is about 8 per cent. immediate death. After operations where the sacrum is divided, and the peritoneum opened, the mortality is 18 to 20 per cent. These calculations are based on a number of cases done by various surgeons. But the results must vary in the hands of different surgeons, and with the selection of cases. Mr. Watson-Cheyne is inclined to think that this mortality of 18 to 20 per cent. is rather a high one, because it is founded upon German statistics, and German surgeons certainly operate upon cases which we should not operate upon. They select cases some of which are those where there are adhesions to neighbouring parts. I think we should consider these cases as beyond the pale of operation. So that I think we may say this 18 to 20 per cent. is rather a high estimate. If you base your calculations on cases where the disease can be easily limited by the finger, where there are no adhesions, and where the patient is in fairly good health, I think that the operation, if carefully done, would be attended by a mortality of considerably under 18 per cent. Although at the present time we cannot speak quite possitively on the subject, yet I think the rate of mortality would come out somewhat in that way.

Now with reference to colotomy in this connection. Inguinal colotomy practically ought to

carry no mortality. Taking a number of cases the mortality comes out at about 2 to 3 per cent., but inguinal colotomy done, of course, when there is no obstruction, should be practically a uniformly successful operation. If done when there is obstruction, there is, of course, more risk, and the mortality would go up.

So that excision of the rectum is attended by a mortality of about 18 per cent., and I think we ought to write down inguinal colotomy as carrying no mortality in those cases where there is no obstruction.

Now what is the prognosis after excision of the rectum? Here, again, we have to rely chiefly upon German writers. Mr. Cheyne collected about one hundred cases of excision of the rectum, done by various surgeons, and sixty-one of the patients were no better off for the operation, certainly not so well off as if colotomy had been done. Of these sixty-one patients, twenty-seven died at once, and of the remainder there was an early recurrence of the disease in them all. Thirty-three out of the hundred patients gained great advantage from the operation, much more than if they had been simply colotomised, and they lived from four to sixteen and a half years. It does not say what became of the balance, but these were all confirmed cases of cancer of the rectum. So that if we can get our cases of cancer of the rectum early, there is no doubt we shall be able to write much more favourable statistics than we can at the present time; and getting them early means, of course, more careful investigation of these rectum symptoms, in order to catch the disease before it has reached any of the neighbouring parts.

So that in selecting a case for operation, you may say that when the part is easily movable, easily limited by the finger, is not adherent, and is of a hard texture, the prognosis is good. But you have to leave open the question of glandular infection, which you cannot always determine, and also the question of secondary deposits, and you have to remember that even in small cases of cancer of the rectum there may be secondary deposits of which you have no notion whatever.

Guy's Hospital Dental Society.

LIST OF NEWLY-APPOINTED OFFICERS.

President: A. E. Baker, M.R.C.S., L.R.C.P., L.D.S. Vice-Presidents: J. W. Pare, M.D., C.M., L.D.S.; J. F. W. Silk, M.D.; J. L. Payne, L.D.S.; E. B. Dowsett, M.R.C.S., L.R.C.P., L.D.S. Honorary Secretary and Treasurer: S. L. Prall. Committee: P. H. Hayes Palmer, L.D.S.; J. H. Wilkes; E. W. Corfe; G. H. Morris.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

CASES UNDER DR. PYE-SMITH.

MARY	25, 33.	Exophthalmic goitre.
	26.	Acute rheumatism.
	27.	Broncho-pneumonia.
	28.	Acute rheumatism. Mitral regurgitation.
	29.	Empyema.
	31.	Thyroid growth. Tracheotomy.
	32.	Lobar pneumonia.
	34.	Infective endocarditis.
	37.	Mitral regurgitation.
PHILIP	23.	Tuberculous peritonitis.
	24.	Acute rheumatism. Mitral stenosis and regurgitation. Aortic regurgitation.
	25.	Mitral stenosis and regurgitation.
	26.	Mitral regurgitation. Aortic regurgitation and stenosis.
	28.	Aneurysm of ascending aorta and innominate.
	29.	Lobar pneumonia.
	34.	Pneumonia.
	35.	? Tuberculous peritonitis.
	36.	Hypertrophied and dilated heart.
	37.	Acute nephritis.
	39.	Nephralgia. ? Calculus.
	40.	Carcinoma ventriculi.

CASES UNDER DR. TAYLOR.

MARY	38.	Neuritis.
	40.	Exophthalmic goitre.
	42.	Carcinoma ventriculi.
	43.	Bronchitis.
	44.	Appendicitis.
	45.	Anæmia.
	48.	Gastric ulcer.
	49.	Pneumonia. ? Pleurisy.
	50.	Empyema.
STEPHEN	1.	? Broncho-pneumonia.
	2.	Pleuritic effusion.
	3.	Right lobar pneumonia.
	5.	Enlarged thyroid. Rapid heart. Old cardiac disease.
	6.	Acute Bright.
	7.	Ascites. ? Cause.
	9.	Diabetes mellitus.
	10.	Mediastinal growth.
	11.	Tubal nephritis.
	12.	? Granular kidney.
	13.	? Plumbism.
	14.	Recurrent appendicitis.
	15.	Abdominal tumour. ? Tubercular peritonitis.

Stephen 16. Mitral stenosis.
19. Locomotor ataxy.
20. Carcinoma of stomach.

Cases under Dr. Hale White.

Philip 1. Diabetes mellitus.
2. Gonorrhœal arthritis and conjunctivitis.
4. Acute nephritis.
5. Transverse myelitis. Syphilitic.
7. Cirrhosis. Tobacco amblyopia.
8. Phthisis. Tubercular ribs.
9. Empyema.
10. Hodgkin's disease.
11. Chronic peritonitis.
12. ? Carcinoma ventriculi.
13. Athetosis.
14. Eczema.
15. Acute phthisis. Mitral stenosis.
16. Thoracic aneurysm. Descending aorta.
17. Acute rheumatism.
18. Acute rheumatism. Relapsed.
19. Mitral regurgitation.
Mary 13. Chorea.
14. Aneurysm.
15. Mitral regurgitation.
18. Gastro-enteritis.
20. Hemiplegia.
21. Gall stones.
22. Cerebral tumour.
24. ? Colitis.

Cases under Dr. Pitt.

Mary 2. ? Enteric.
3. Acute rheumatism.
6. Cirrhosis of liver. Paracentesis abdominis.
7. Appendicitis.
8. Exophthalmic goître.
12. Empyema.
Stephen 22. Hodgkin's disease.
23. Diabetes mellitus.
24. Emphysema.
26. Pericarditis.
34. Chorea. Adult.
36. Cerebral hæmorrhage.
38. ? Spinal caries. ? Commencing Addison's disease. ? Renal calculus.

In the Surgical Wards.

Cases under Mr. Howse.

Naaman 1. Mastoid abscess. Antrectomy.
4. Cysto-sarcoma of submaxillary gland Excised.
5. Tuberculous tarsus. Scraped.
6. Hæmatocele. Incised and drained.
8. Spinal caries. Gluteal abscess. Incised.
12. Sarcoma of foot. Stokes-Gritti amputation.
Naaman 14. Recurrent supra-orbital epithelioma.
17. Multiple painful lipomata.
Dorcas 1. Æt. 4. Fractured femur. Double Bryant.
3. ? Renal calculus.
4. Hip disease.
5. Mastoid abscess. Antrectomy.
6. Bullet in skull. Extracted.
7. Recurrent carcinoma mammæ. Excised.
8. Carcinoma mammæ. Excised.
9. Tuberculous knee. Excised.
10. Ankylosed flexed knee. Excised. Lupus hypertrophicus of face.
13. Fractured femur. Hodgen.
14. Sinus after Furneaux-Jordan.
15. Syphilitic arthritis of knee.
16. Æt. 6. Fractured femur. Double Bryant.
17. Chronic mastitis.
Cot A. Mastoid abscess.
B. Spinal caries.
C. Vesical calculus.
Astley Cooper 4, 6, 26, 32. Burns.
5. Dislocated elbow.
9. Supra-condylar fracture of femur.
Cot. Fractured base.

Cases under Mr. Davies-Colley.

Job 1. Strangulated inguinal hernia. Kelotomy.
3. Epithelioma of lip. Excised.
4. Spinal caries with sinus.
5. Tuberculous knee. Excised.
6. Tuberculous knee.
7. Tuberculous tarsus. Scraped.
8. Iliac abscess.
10. ? Lipoma in posterior triangle.
11. Sacro-coccygeal congenital tumour. Excised.
12. Lumbar abscess. Incised.
20. Cleft palate and hare lip. Cheiloplasty.
21. Tuberculous ankle. Syme.
Lydia 1. Abdominal contusion.
2. Tuberculous shoulder. Incised.
3. Fractured os calcis.
4. Adenoma mammæ. Excised.
5. Strangulated umbilical hernia. Kelotomy.
6. Hydatid of liver. Drained.
7. Concussion with cerebral irritation.
12. Fractured ribs.
14. Intracapsular fracture of neck of femur. Hodgen.
15. Umbilical hernia. Radical cure.
17. Carcinoma mammæ. Breast excised.
18. Renal calculus.
Cot A. Fractured femur. Vertical suspension.
B. Double otitis media.
C. Strangulated inguinal hernia. Reduced.

CORNELIUS	4.	Fractured femur. Liston's splint.
	9.	Fractured ribs.
	11.	Fractured ribs with hæmoptysis.
	12.	Fractured pelvis.
	17.	Fractured femur. Hodgen.
	20.	Hæmatoma of scrotum. ? Acute hæmatocele.

CASES UNDER MR. LUCAS.

LAZARUS	2.	Syphilitic laryngitis. Tracheotomy.
	3.	Gluteal abscess and spinal caries.
	4.	Appendicular abscess. Incised.
	5.	Tuberculous tarsus. Syme.
	7.	Tuberculous wrist.
	10.	Enlarged prostate.
	16.	Spinal caries and lumbar abscess.
	20.	Epitheliomatous glands in neck. Excised.
	21.	Hip disease and gluteal abscess.
MARTHA	1.	Epithelioma of anus. Excised.
	2.	Rachitic tibiæ. Osteotomies.
	3.	Carcinoma mammæ. Excised.
	5.	Tuberculous elbow. Excised.
	6.	Mastoid abscess. Antrectomy.
	8.	Mastoid abscess. Antrectomy.
	14.	Tuberculous tarsus. Pirogoff.
	15.	Fractured femur.
	19.	Tuberculous tarsus.
	21.	Calculous pyonephrosis. Nephrolithotomy.
Cot	A.	Fractured femur. Vertical suspension.
	D.	Fractured femur.
ASTLEY COOPER	11.	Fractured femur.
	18.	Dislocated ankle.
	21.	Fractured femur.
	26.	Fractured ribs and sternum.
	27.	Fractured ribs.
	29.	Ruptured liver.

CASES UNDER MR. GOLDING-BIRD.

LUKE	6.	Movable kidney. Nephrorraphy.
	8.	Papillomata of rectum. Excised.
	10.	Urinary fistula.
	13.	Cystitis and enlarged prostate.
	14.	Tuberculous shoulder.
	15.	Tuberculous knee.
	16.	Sarcoma of neck. Excised.
	20.	Gonorrhœal synovitis of knee.
CHARITY	2.	Carcinoma mammæ. Excised.
	3.	Lipoma on buttock.
	9.	Ruptured urethra.
	10.	Cervical dermoid. Previously incised and drained.
	12.	Nævus on tongue.
	14.	Sarcoma of femur. Amputation through thigh.
	16.	Loose body in knee.
Cot	A.	Hare-lip and cleft palate. Double.
	C.	Tuberculous tarsus.
ASTLEY COOPER	5.	Fractured humerus. T-shaped into elbow.

CASES UNDER MR. JACOBSON.

NAAMAN	19.	Dislocation of first metacarpo-phalangeal joint. Resection.
	20.	Semimembranosus bursitis. Excised.
	21.	Chancre with phimosis. Circumcision.
DORCAS	19.	Tuberculous cervical adenitis. Excised.
	20.	Tuberculous cervical adenitis. Excised.
	22.	Sarcoma of groin. Excised.
Cot	D.	Rachitic tibiæ.
PATIENCE	2.	Acute cervical abscess. Incised.
	3.	Senile gangrene of feet.

CASES UNDER MR. SYMONDS.

JOB	13.	Stricture. External urethrotomy.
	14.	Syphilitic laryngitis.
	16.	Nasal polypi. Frontal sinus empyema. Explored.
	17.	Cleft palate.
	18.	Carcinoma laryngis. Tracheotomy.
	19.	Lympho-sarcoma of fauces with glands involved.
LYDIA	19.	Parenchymatous goitre. Partial excision.
	20.	Œsophageal stricture. Gastrostomy.
	21.	Tuberculous knee. Excised.
	22.	Ovarian cystoma.
RUTH	35.	Syphilitic perichondritis of larynx.

CASES UNDER MR. LANE.

LAZARUS	11.	Hypospadias and undescended testes. Plastic operation.
	12.	Renal calculus.
	13.	Displaced semilunar. Excised.
	14.	Tuberculous knee.
MARTHA	11.	Recurrent appendicitis with abscess. Excised.
	13.	Hydatid of liver. Drained.
Cot	C.	Old necrosis of femur. Bone transplanted.

CASES UNDER MR. DUNN.

LUKE	1.	Focal epilepsy. Trephined.
	2.	Clin. P. R. Old pylorectomy. Recurrent cancer in parietal scar. Excised.
	4.	Tuberculous knee.
	18.	Lymphangitis of arm.
CHARITY	18.	Appendicitis. Recurrent.
	20.	Umbilical hernia. Radical cure.
	21.	Cancer of breast. Excised.

Papers by Guy's Men.

Remarks on Climate and Sea-Voyages in the Treatment of Tuberculosis. By Sir Hermann Weber, M.D., F.R.C.P.—*British Medical Journal*, June 3rd.

Four Unusual Cases of Hernia. By R. Lawford Knaggs, F.R.C.S.—*Ibid.*

The Accurate Localisation of Intra-Cranial Tumours, excluding Tumours of the Motor Cortex, Motor Tract, Pons, and Medulla. By Dr. Newton Pitt.—*Brain*, No. 83.

Nursing Notes.

THE great event came off on the 31st; a perfect day, and we had a flying run down to the "Fox." "Did we lose anything"? Oh! I am not talking about the Derby, but Guy's Cycling Club Invitation Picnic. It was a great success; we went to the "Fox" Inn, at Hayes, and were Sister Esther's guests at tea.

There were only twelve altogether, though judging by the negociations that went on ages beforehand for half-days one would have thought there would be many more. If they had been of the opposite sex everyone would have suspected that Epsom had some connection with the matter. I wasn't at the picnic myself, but that is another story.

There is plenty to see at Hayes and Keston. There is a choice and genuine windmill planted there; no opportunity should be lost for seeing these articles, they are becoming scarce, and the time is coming when people will make collections of them and keep them in their gardens.

Unfortunately there was one little mishap on the journey. When the pieces were picked up and sorted out, one batch went to the bicycle shed, and the other went off duty for a day or two. One is all right now if the other isn't.

It looked as if there were a matinée on the other day, rows of empty chairs in the park, a stern porter at the gate, and a crowd of nurses outside waiting to be let in. Nevertheless no one occupied the chairs till seven in the evening. If the nurses' "feet could cross the meadows and leave the daisies rosy" it would be a good thing; in plain language—Please tread lightly as we want the lawn nice for prize day.

The smart and the correct thing this season will be the roof teas over the Nursery. There are good sized tubs on the top; here we are troubled in our mind—are they the remains of the British workman (for the trail of the serpent is all over the place) or are they to be filled with flowers? Some one said they had seen the gardener planting nasturtium seeds; if so the hanging gardens of Babylon won't be in it.

This story is for those who know the Second Book of Kings:—A junior probationer of some few days standing was sent as an "extra" into Naaman ward. Arrived up there she looked around, and then said to the Sister, "Oh! Sister, where are the lepers? I should so like to see one!"

"L'INCONNUE."

Royal College of Surgeons of England.

ORDINARY COUNCIL, 8TH JUNE, 1899.

LIST OF EXAMINERS ELECTED BY THE COUNCIL.

BOARD OF EXAMINERS IN ANATOMY AND PHYSIOLOGY FOR THE FELLOWSHIP.

ANATOMY.—James Ernest Lane, Frederick Gymer Parsons, Alfred Harry Young, Berkeley G. A. Moynihan.

PHYSIOLOGY.—Ernest Henry Starling, D'Arcy Power, William Henry Thompson, Thomas Gregor Brodie.

COMBINED EXAMINING BOARD.

FIRST EXAMINATION.

ELEMENTARY BIOLOGY.—Peyton Todd Bowman Beale. Thomas George Stevens, Thomas William Shore, Frederick Gymer Parsons.

SECOND EXAMINATION.

ANATOMY.—William Bruce Clarke, Stanley Boyd, Arthur Robinson, Arthur Thomson.

PHYSIOLOGY.—John Rose Bradford, Leonard Erskine Hill, George Alfred Buckmaster.

THIRD EXAMINATION.

MIDWIFERY.—Arthur Hamilton Nicholson Lewers. Herbert Ritchie Spencer, William Radford Dakin, Walter Spencer Anderson Griffith.

EXAMINATION IN PUBLIC HEALTH.

PART I.—Arthur Pearson Luff.

PART II.—Sydney Arthur Monckton Copeman.

EDWARD TRIMMER.
8th June, 1899. Secretary.

Notice.

GUY'S HOSPITAL COLONIAL CLUB.

The Second Annual Dinner of this Club will be held in the Prince's Salon, Holborn Restaurant, at 7.30 p.m., on Friday, the 23rd instant. Tickets will cost 6s. each.

Those who intend to be present are requested to communicate before Wednesday, the 21st, with

F. G. GIBSON, Hon. Sec.

From the Gazette's Special Pathologist.

H. R. M., HASTINGS.—Tubercle bacilli are present in the sputum in fair numbers. PATHOLOGIST.

Passim.

WE have great pleasure in publishing in this number of the GAZETTE a note by Sir Samuel Wilks on "Appendicitis." It is in the nature of a protest against the modern idea that appendicitis is a newly-discovered pathological condition. As Sir Samuel Wilks points out, the only new thing is the name, "appendicitis," and the question of operation before the formation of a tumour; for the rest, Addison knew just about as much on the subject as we do now, and wrote about it as long ago as 1836. Verily, every day the truth is brought more nearly home to us that "there is nothing new under the sun."

AND the article itself serves as a text for us to again appeal to all Guy's men to send us articles and accounts of interesting clinical material. If the President of the College of Physicians can find time to write for the GAZETTE—and we are deeply grateful to him for the favour—surely among the multitudes of Colonnade walkers here there must be some who have more time and opportunities to make the GAZETTE interesting.

IT is part of our creed that the GAZETTE is a paper run by the students for the students, and the irony of the situation is that the students practically do less for the GAZETTE than the Staff. The gratuitous labour which is expended by both physicians and surgeons in turn in preparing clinical lectures every fortnight for publication in the GAZETTE, ought to shame the men themselves to occasionally lift a finger towards the same cause. To have to make bricks without straw once a fortnight, and for the rest of the time to receive complaints against the poor qualities of the bricks, gets monotonous, and is moreover an injustice to the editorial committee.

WE have been asked to say a few words upon a subject which is particularly galling to all right-minded men who use the grounds at Honor Oak Park. Some men, luckily for them nameless, have taken to playing Tennis down at the ground in their ordinary clothes, and the other fellows who have to play in the same ground with them object, and rightly too. It is a beastly habit, and we do not wonder that it has caused much indignation. If men have not the innate decency to know how to behave they ought to be prevented from bringing disgrace on the other men at the hospital. We hope a rule will be made which will prevent men from playing unless in proper clothes.

IN the Cricket Cup ties things have gone well with the Hospital so far. On June 5th we met Westminster Hospital and won by 97 runs. Guy's batted first and made but a poor show during the first part of the innings owing to the uncertainty of the wicket, but later matters improved chiefly owing to a good innings of 54 by Willan. Westminster started well, but owing to the excellent bowling of Trubshaw and Strange, were soon disposed of, leaving Guy's the victory.

As Charing Cross have scratched, Guy's meet St. Thomas's in the second round on Monday, June 19th, at Chiswick, where we hope the same success will await us.

WE would call the attention of all Colonial men at Guy's to a notice which will be found in another column of the GAZETTE of the second annual dinner of the Guy's Hospital Colonial Club, which is to be held on Friday, the 23rd inst., at the Holborn Restaurant. The only qualification necessary for membership is birth or residence in India or the Colonies, and its purpose is to promote *camaradere* among men scattered in all parts of the world, with common interests. We are requested to state that old Guy's men as well as present will be very welcome. The Secretary of the club is Mr. F. G. Gibson, Guy's Hospital.

The annual Athletic Sports will be held on Wednesday next, June 21st, at Honor Oak Park. Further particulars can be found on the notice-boards in the smoking-room. Mrs. Pye-Smith has kindly consented to give away the prizes.

THE annual Inter-Hospital Athletic Meeting will take place this year on Wednesday, July 12th, at the London Athletic Club Ground at Stamford Bridge.

DR. LOCKHART STEPHENS' demonstrations on the Sandow method of physical culture, last week, was a great success. The smoking-room was filled with a most appreciative audience, who gave him the hearty welcome he most justly deserved. If the system needed any justification, Dr. Stephens' unbounded enthusiasm and eminently healthy appearance were

splendid credentials. Mr. Rowland Hastings gave a demonstration of the various exercises, and was a living tribute to their excellence.

As a result, there is already some talk among the more obese of the Residents to form a Sandow class, so Dr. Lockhart Stephens will have the pleasure of knowing that his words have not fallen upon barren ground.

Finally, we hope that Dr. Stephens will find the report of the proceedings in this number more accurate and more to his liking than were the much-abused prefatory notices in the last number of the GAZETTE.

As in all other things, fashion changes with great regularity in the matter of the popular after-dinner games in the park at the Hospital. For the last three months stump cricket in the laundry yard has been the game *par excellence*, to the greater or less detriment of the Hostel windows. The acute diplomatists in charge of the laundry department have effectually stopped this by filling the yard with wet sheets hung out to dry at eventide, so now the Residents' superfluous energy has taken the form of tugs-of-war between rival firms — for the men a most enjoyable pursuit, accompanied with much labour and sweat, and more shouting. The patients in Clinical, however, cannot really regard these contests with much enthusiasm, just as they want to go to sleep. As someone has suggested, what is really wanted is an asphalted playground with a giant stride and parallel bars, for the boys to play in.

WE have to thank the Electrophone Company, and more particularly Mr. Charles Booth, the Managing Director, for a novel idea for Hospital Sunday, which was carried into effect on Sunday last. At the entire expense of the Company, electrophone receivers were placed in many wards of the hospital and connected with sixteen of the principal London churches, so that on Hospital Sunday the patients in the wards here could hear the sermons being preached on their behalf. Two services were given, one in the morning and one in the evening, to the great pleasure of all the patients who were well enough to listen. We can only express our thanks and hope that the experiment may be repeated in the future.

ON Tuesday next, the Residents will give a concert to the Nursing Staff in the Court Room by permission of the House Committee. The concert will be divided into two parts, so that both day and night nurses can attend, the first part commencing at 7.30 and the second part at 9 p.m.

THE Colonnade pavement is now finished, and is an unqualified success. The bolder patterns at either end are, we think, rather more successful than the central portion, but in matters of decoration there are so many opinions, to wit, the controversy at St. Paul's Cathedral. Anyhow, the Hospital owes a very deep debt of gratitude to Mr. Bonsor for his liberality in so effectually improving our front entrance. The only drawback is that the rest of the Colonnade looks so pitifully shabby in comparison. Will not somebody else do that up?

DURING the last three days of this month a large basket will be placed in the College Lodge for the reception of cast-off clothing of every description. The Samaritan Fund will arrange its distribution to hospital patients, who are often totally destitute of the bare necessities. Even top hats will be of use to intending bus-drivers; and bundles of women's and children's clothes from home will be invaluable. Many men will be glad to find this vent for their wardrobe litter, and for this charity; and if the experiment is successful it will be repeated at the end of every quarter.

Obituary.

Leonard Slater.

WE deeply regret to announce the death of Leonard Slater, M.B., B.C, which occurred quite suddenly at Northampton, this week. He had been suffering from the effects of influenza for the last few weeks, and was away in the country for a holiday. After a long bicycle ride to Northampton he suddenly developed pneumonia, and was taken to the Infirmary, where he died on Tuesday last.

Leonard Slater came to Guy's in 1891 as a third year's student, having been at Caius College, Cambridge. He qualified in 1894, and was subsequently both H.P. and R.O. here. In 1896 he settled down in practice at Finchley, where he remained till his last illness. A hard working forward in the Rugby Football team, and President of the Residents, he was one of the most popular men of his time, and his sudden and unexpected death will come as a great shock to all who knew him at Guy's.

The Battle of the Strong.

DR. LOCKHART STEPHENS is a man who having found a great joy calls in his neighbours to share it with him. For some months past he has been personally investigating Sandow's System of Physical Culture, with the result that he is Sandow's—heart, soul and body. On Thursday of last week he came down to Guy's accompanied by Mr. Rowland Hastings to communicate his enthusiam to his fellow Guy's men, and judging by the warm applause of a large (and fashionable) audience he succeeded. Dr. Pavy presided at the meeting and Mr. Dunn represented the surgeons, Dr. Fawcett the physicians, Messrs. Handley and Stewart anatomy, and Mr. Bellingham Smith was present in the gynæcological interest.

After some prefatory remarks on the subject of exercise in general, Dr. Stephens pointed out that whereas other forms of exercise, however good in themselves, were only available for the leisured few, Sandow's system was open to everyone. He upheld a systematic course as opposed to free and easy methods; half measures have no place in Sandow's system, and those who would follow that system must be prepared to work.

Dr. Stephens' gospel is "The Fascination of Fitness;" he says that it is no hardship to a man who is perfectly fit to forego any luxury that will interfere with his fitness. He told of a patient of his who said, "Good sir, I don't live, I just bide about," and that, he thinks, is the condition of the man out of training, he just "bides about."

Mr. Frederick Treves has laid down six essentials of exercise, viz:—

1. Exercises must be adapted to meet the needs of the individual case.
2. They must be carefully devised and suitably graduated.
3. They must be carried out under proper guidance and with suitable and efficient instruments.
4. The time must be carefully selected.
5. The exercises should be taken in the open air or a well-ventilated room.
6. The pupil should be properly clad.

Sandow's system fulfils all these conditions, a pair of 4-lb dumb-bells representing the "suitable and efficient instruments"; but he also adds a seventh clause—"the pupil should take a cold bath when still sweating." This, Dr. Lockhart Stephens confesses, he jibbed at at first, but he is now convinced that it is sound.

Touching on the medical aspect, the lecturer advocated gentle movements during typhoid convalescence, and thought that the system opened up a new field in the after-treatment of fractures; in this last, however, we cannot go quite all the way with him. The value of early movement and massage is now pretty well established, but it has been introduced by men who knew not Sandow, and it would be hardly fair to credit him with the principle.

Mr. Rowland Hastings demonstrated the various exercises of the regular system and afterwards gave an exhibition with a 55-lb. bar-bell. Mr. Hastings is a splendidly developed man as far as muscles go, and he was greeted with the greatest enthusiasm. He has only been under Sandow for five months, and is certainly a good advertisement for the system.

The proceedings terminated with a hearty vote of thanks to Dr. Lockhart Stephens and Mr. Rowland Hastings, and another to Dr. Pavy, whose presence and approval added lustre to the proceedings.

The evening was in every respect an instructive and an enjoyable one, and Dr. Stephens certainly created an impression. For ourselves, we envied him his enthusiasm, and envied him his fitness; but most of all we envied him a practice the magnitude of which renders a quarter of an hour with dumb-bells the only form of exercise available.

Reviews.

Origin and Antiquity of Freemasonry. By Albert Churchward, M.D. (Sir Joseph Causton & Sons).

Dr. Churchward has written a book on this subject that will probably be read by the outside public as eagerly as by Guy's Masons. The obscurity of the subject and the ever-increasing conviction that the proudest boasts of Masons may have some historical basis, renders any attempt at elucidation very interesting. The uninitiated will doubtless cavil at the mathematical figures pourtrayed and dub the explanations fantastical, but to antiquarians and earnest Masons the book will be full of interest.

Searchers into a masonic past have hitherto turned their eyes to the comparatively modern Jewish system for explanations of their traditions. The tendency now-a-days is to explore the more ancient mysteries, those of the Chinese, the Hindu, the Egyptian, and most interesting of all, the curious signs recently noticed in remote and ill-known parts of Mexico, and Central America.

Dr. Churchward holds the key to the mysteries to be in Egypt, and brings forward much evidence to that effect.

The connection of medicine with mystery was very marked during the middle ages, and has not entirely ceased at the present day; but in the ancient days of Freemasons that this book speaks of, the Egyptian priests (? Masons) were the doctors (!) of the day, and there is something appropriate in the interest displayed at the present day by doctors in the Origin of Freemasonry.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

A Case of Cerebral Hæmorrhage Complicated by a Sub-hyaloid (retinal) Hæmorrhage.

THE following case is at present in Stephen ward, under the care of Dr. Pitt, who has kindly allowed me to publish it.

W. M., æt. 48, left home early on the morning of Saturday, April 22nd, and shortly afterwards was suddenly seized with pain on the right side of his head, staggered, became unconscious, and was conveyed home.

He remained under the care of his doctor until May 2nd, when he was removed to Guy's Hospital. His condition on admission is reported as follows:—

The left arm is weaker and colder than the right, and the left leg also shows some loss of power.

Slight facial paralysis was noticed on the left side. Drooping of the left eyelid. The pupils reacted to light and accommodation, but the right was larger than the left.

Both eyes were examined in the course of a routine examination, the patient himself not having drawn attention to any defect in them, and it was during this examination that attention was attracted to the condition of the right eye; the left being normal. The vision of the right eye on May 28th, when I first saw the patient, was only $\frac{4}{60}$, that of the left being $\frac{6}{5}$.

As far as the patient was aware he had never entirely lost the sight of that eye, or been unable to fix centrically. Objects had not appeared of a red colour to him. On this latter point, however, I was able to ascertain that by making him fix an object, a lighted match when held above appeared red to him.

The hæmorrhage does not appear to have involved the macula, but is just below the fovea centralis, which is very indistinctly seen, owing to the surrounding œdema of the retina. The vitreous is hazy, and some opacities due to a small quantity of hæmorrhage can be seen floating about.

The fundus appears to be quite healthy in the periphery.

A well-marked physiological cup is present in the centre of the optic disc.

The upper level of the hæmorrhage is below the centre of the disc, and extends from a point about half a disc's breadth on the outer side to some distance beyond the macula, becoming gradually merged into the fundus beyond.

The upper border is horizontal.

The inner border extends obliquely downwards until it reaches the level of the inf. temporal vein, which makes a sharp curve to the outer side, and appears to limit the hæmorrhage, altering its course, and partially suspending it as a cord suspends a cushion, the vein being partly hidden by the overhanging mass. Beyond this part the hæmorrhage takes an almost horizontal direction inwards and then curves outwards and slightly downwards to the outer side, where another notch, smaller, but almost on the same level is found. Subsequently the outer margin passes upwards, becoming more and more indistinct.

On examining the patient ten days later I noticed that the two notches had joined, severing the lower portion, which now existed as a separate hæmorrhage, below the larger and more central one, the fundus between the two being quite normal, and a small vessel was noticed passing from one to the other. At this time also some evidence, at the outer and upper edge, was noticed that the mass was changing its character and becoming absorbed.

The colour, shape, and position of the hæmorrhage sufficiently established the question of diagnosis.

Sub-hyaloid hæmorrhages are not perhaps so rare as may be imagined, but are of interest on account of the discussion which has been carried on with regard to their exact position and the reason why they almost invariably assume the semicircular shape.

Only one case, as far as I know, has been examined microscopically, and in that case the hæmorrhage existed between the nerve fibre layer and the internal limiting layer of the retina, and had burst through in one spot the limiting layer and the hyaloid, and was stretched out over the inner surface of the hyaloid membrane. *Vide* R.L.O.H. Reports, Vol. xiv., Pt. II.

The hæmorrhage, on account of its size and the little disturbance of surrounding parts and spontaneous cessation is thought to be venous in origin, but nothing certain is known on this point; whether this be so or not this condition is not unfrequently found in connection with hæmorrhage of a cerebral artery. They are always situated in the macular region, often involving the fovea centralis.

In the case before us two or three points of especial interest may be pointed out—

1. The shape of the hæmorrhage when first seen appeared to be modified by the inf. temporal vein as represented in Diagram I.

If this is so the cavity which is described as existing between the hyaloid membrane and the retina in the macular region can only have a relative existence, and the connection between the hyaloid membrane and the retina is stronger along the course of the vessels.

2. The separation of the lower portion of the hæmorrhage when examined a few days later, so that the appearance represented in Diagram II. was seen. Here there seems to be sufficient resistance to a separation of the two membranes to support the upper hæmorrhage and keep it distinct from the lower.

3. The absence of any central scotoma, due to the hæmorrhage being below the macula lutea, and the red colour given to objects when viewed indirectly.

The difficulty experienced in obtaining specimens for microscopical examination, renders the settling of the question as to the exact cause of the position and shape of these hæmorrhages a difficult one.

The prognosis is good, the mass clearing up and becoming absorbed, leaving little or no permanent damage.

A. W. ORMOND.

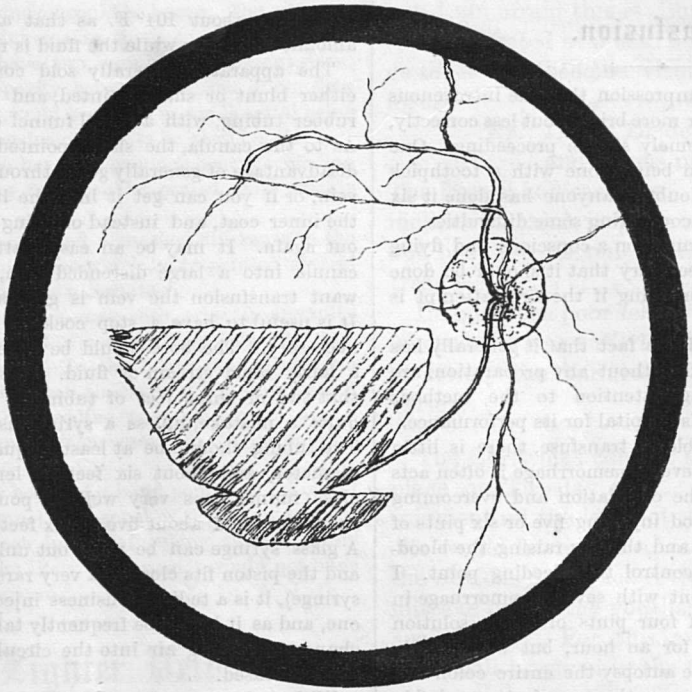


Diagram I.

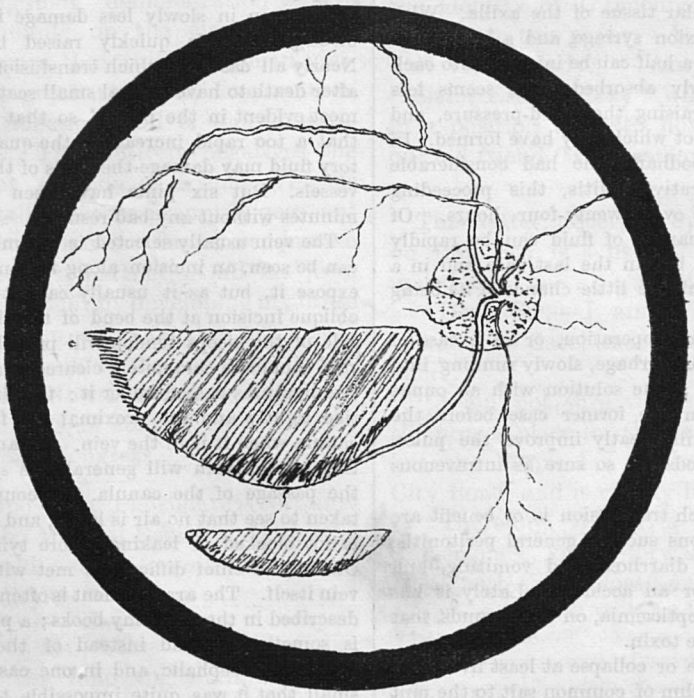


Diagram II.

Transfusion.

THE books give one the impression that the intravenous injection of saline fluid, or more briefly, but less correctly, Transfusion, is an extremely simple proceeding. One reads accounts of it even being done with a toothpick and a Higginson, but I doubt if anyone has done it six or more times without encountering some difficulties.

As it is generally performed on a conscious and dying patient, it is extremely necessary that it should be done quickly, and it is very mortifying if the first attempt is not successful.

Its extreme utility, and the fact that it generally has to be done in a hurry and without any preparation, are my apology for drawing attention to the methods generally employed in this hospital for its performance.

As to when it is advisable to transfuse, there is little question that after any severe hæmorrhage it often acts like magic in restoring the circulation and overcoming collapse. But it is no good injecting five or six pints of fluid into the circulation, and thereby raising the blood-pressure, if you cannot control the bleeding point. I have seen a typhoid patient with severe hæmorrhage in whom the transfusion of four pints of saline solution had a marvellous effect for an hour, but who rapidly sank after that, and at the autopsy the entire colon was filled with blood. In this case the transfusion probably directly prevented Nature's method of arresting hæmorrhage. In such a case it seems more rational to inject saline fluid into the cellular tissue of the axilla. With the needle of an antitoxion syringe, and a good glass syringe, about a pint and a half can be injected into each axilla, and as it is slowly absorbed there seems less likelihood of suddenly raising the blood-pressure, and thereby dislodging any clot which may have formed. In a patient under Dr. Goodhart, who had considerable hæmorrhage with ulcerative colitis, this proceeding improved her pulse for over twenty-four hours. Of course, a considerable quantity of fluid can be rapidly absorbed by the rectum, but in the last case and in a case of typhoid there would be little chance of its being retained.

After a severe abdominal operation, or in a case of moderate post-partum hæmorrhage, slowly running into the rectum two pints of saline solution with an ounce and a half of brandy (in the former case before the patient comes round) will greatly improve the pulse. But none of these methods are so sure as intravenous injection.

Other instances in which transfusion is of benefit are severe abdominal conditions such as general peritonitis, uræmia, diabetic coma, diarrhœa and vomiting, and shock following burns or an accident. Lately it has been recommended for septicæmia, on the grounds that it aids the excretion of the toxin.

In cases of hæmorrhage or collapse at least five pints of a solution of one drachm of common salt to the pint of boiled water should be injected. The temperature should be about 104° F. as that allows for a certain amount of cooling while the fluid is running in.

The apparatus generally sold consists of a canula, either blunt or sharp pointed, and a few feet of india rubber tubing, with a small funnel or syringe of glass. As to the canula, the sharp pointed one has the great disadvantage of generally going through both sides of the vein, or if you can get it into the lumen it catches on the inner coat, and instead of going up the vein comes out again. It may be an easy matter to pass a sharp canula into a large distended vein, but in cases that want transfusion the vein is generally quite collapsed. It is useful to have a stop cock on the canula, but not necessary. The bore should be large enough to allow of a fairly rapid stream of fluid. Most of the books say that two or three feet of tubing is sufficient. This is quite a mistake, unless a syringe is going to be used. The tubing should be at least a quarter of an inch in diameter, and about six feet in length. An ordinary glass funnel does very well to pour the fluid in and should be held about five or six feet above the patient. A glass syringe can be used, but unless it is a large one and the piston fits closely (a very rare quality in a glass syringe), it is a tedious business injecting five pints with one, and as it has to be frequently taken off to refill, the chances of letting air into the circulation are considerably increased.

With a funnel and sufficient pressure five pints can easily be injected in fifteen to thirty minutes. As to the rapidity with which the fluid is injected, some think that if run in slowly less damage is done than if the blood-pressure is quickly raised by rapid injection. Nearly all cases in which transfusion is done are found after death to have several small scattered hæmorrhages, most evident in the pleura, so that it is quite possible that a too rapid increase in the quantity of the circulatory fluid may damage the walls of the smaller collapsed vessels. But six pints have been injected in fifteen minutes without any bad result.

The vein usually selected is the median basilic. If it can be seen, an incision along its length can be used to expose it, but as it usually cannot in these cases, an oblique incision at the bend of the elbow over the inner side of the biceps tendon will probably include it. The vein should be completely cleared for about an inch and two ligatures passed under it: the distal one should be tied tightly and the proximal left for tying round the canula when it is in the vein. A transverse incision half through the vein will generally be sufficient to allow of the passage of the canula. Of course, care should be taken to see that no air is let in, and that the apparatus is not blocked or leaking, before tying it into the vein. One of the chief difficulties met with is caused by the vein itself. The arrangement is often different from that described in the anatomy books; a plexus of small veins is sometimes found instead of the orthodox median basilic and cephalic, and in one case these were all so small that it was quite impossible to get a canula into them, and the cephalic had to be exposed half-way up

the arm before transfusion could be begun. The collapsed condition of the veins makes them so small that it is really advisable to have two canulas of different sizes; in one case the disparity between the size of the vein and any canula that could be found in the hospital being so great that the transfusion had to be abandoned.

The median basilic has an advantage over the median cephalic in that the fluid can be passed more quickly into the former.

Mr. R. P. Rowlands found a marked difference in the rate of transfusion in a case which he transfused several times, using the two veins alternately.

Most of the difficulties met with arise from faulty apparatus or the neglect of carefully exposing and ligaturing the vein distally. In the latter case the canula is apt to be pushed between the coats of the vein instead of into its lumen, or bleeding may obscure it, and a thrombus forming make it necessary to expose another vein.

The picture in the books of a hand pouring fluid out of a milk jug into a funnel connected with a canula in the vein by about eighteen inches of tubing cannot surely have been drawn from life. I am sure it would not have run in with that pressure. A. J. C.

In Lighter Vein.

THE most instructive portion of Dr. Lockhart Stephens' "strong man" demonstration was, to my mind, his homily on the virtues of Mr. Sandow. It appears that this gentleman, notwithstanding his great strength, is a man of strong domestic affection, and is indeed quite fond of his wife. This entirely negatives the popular idea that as soon as a man's biceps reaches a respectable size he promptly goes out and slugs his old woman on the chest, just to show her that she is a partner in all his joys. It was only the fear that by developing my brute strength I should chip some of the refinement of my mind that has made me forswear dumbbells all this time. Now I intend to keep a pair always handy—unless, of course, they are forbidden by the Peace Congress.

What's in a name? Dr. Phosphate is certainly appropriate for the Medical Registrar, but at the same time it should not be forgotten that uric acid is his speciality.

A patient arrived at "Skins" the other day having received the following note from his medical attendant—

"I am afraid this is Lupus, and it should be at *once* treated at a skin hospital. If allowed to go on it will become virulent. There are two forms

viz., Lupus Exidens
and Lupus non Exidens.

The former is disastrous. At the present I am inclined to think it quite curable. Anyhow, do not hesitate, as only a hospital can properly treat it."

Imagine the poor fellow's solicitude to know whether he was suffering from the virulent form or merely the harmless necessary non exidens variety.

The Christmas concert to the Nurses will take place on Tuesday next. A roof-garden entertainment on the leads of the temporary Nurses' site would have been an attractive novelty, but the obvious drawback is that the Clinicals might mistake one of the vocalists for a cat and act accordingly. For this and other reasons the show will be given in the Court Room.

Writing of nurses, great anxiety exists as to the identity of L'Inconnue, the amusing contributor to this paper. At present she remains "a veiled lady." (Anyone who suggests "Sister Esther Hazy" will be lynched). I am in a position to state, however, that she is *not* our old friend "Gladys," of Guyoscopic fame.

This letter, received by the Superintendent on June 3rd, is a useful check to our "puffed-uppedness":—

"Dear Sir,—I am in receipt of yours of yesterday's date, and thank you for your kind offer.

"I am not sure whether Guy's Hospital is the proper place for the treatment of piles, &c., but the hospital I mean is situated in New City Road, and is chiefly for that purpose.

"Therefore, if Guy's Hospital is not the proper place, kindly forward my previous letter along with the enclosed envelope,

"And oblige,
"Yours truly,
"J. H."

Nasty jar, that, for the surgeons!

Cannot one of our artists invent a decent Guy's tie and hatband? The neighbouring Dental School has several, which are very popular among its members, but as far as one can judge, the hospital has none. Of course, the colours are primarily hideous, but something passable might surely be made out of them, especially if good silk were used. Anyhow, the thing ought to be done.

Nursing News.

WE have to congratulate two of the Sisters on the appointments they have obtained on June 13th. Miss Long (Sister Astley Cooper) was appointed Matron of the Wolverhampton Hospital. Miss Fox (Sister Charity) was appointed Superintendent of Nurses at the Tottenham Hospital. Each of these Hospitals contains more than one hundred beds.

Nurse Mann, who left us about six months ago, has been appointed one of the first two pupils in Tropical Medicine at the Dreadnought Hospital, under the Colonial Nursing Association.

Sister Cornelius has unfortunately caught scarlet fever in the discharge of her duties. We are very glad to be able to report that the attack is a mild one, and she is progressing well.

Nurse Bennett, who was invalided from the same cause, on the same day, is also doing well.

Sport.

Cricket

GUY'S v. REIGATE PRIORY.

Played at Reigate on Saturday, June 3rd. We lost the toss, and Reigate started to bat on a perfect wicket. G. Windsor was caught with the score at 20, but then F. Nightingale and R. P. Neale put runs on at a great pace and soon collared our bowling; with the score at 198, Trubshaw bowled Neale for a fine innings of 103, including 17 fours. Nightingale was caught soon after for 90, the next three wickets added 50, and then came another long stand by Walters and Brabham. With the score at 370 for 7 wickets the innings was declared closed; this gave us about two and a quarter hours to bat, and we started with hopes of playing out time, but the long turn of fielding seemed to have tired our batsmen, and four wickets fell quickly for 30 runs. Langdale and Willan made a stand and carried the score to 67 when the former was bowled. Grellet failed to score, Bush came in and sent up the 100; Dennant made 16, and then Willan was bowled after batting an hour for 46. Cowper and Strange put on 20, but the innings closed for 147. Scores:—

REIGATE.

G. G. Windsor, c Dennant, b Trubshaw	9
F. J. Nightingale, c Poyser, b Graham-Smith	90
R. P. Neale, b Trubshaw	103
J. N. Neale, c Dennant, b Trubshaw	35
R. E. Neale, c Trubshaw, b Graham-Smith	10
F. Nightingale, b Graham-Smith	19
F. W. Brabham, not out	25
A. R. Walters, c Bush, b Bowle	66
Extras	13
*Total (7 wickets)	370

* Innings declared closed.

C. F. Drake, W. A. Windsor, F. C. Morrison did not bat.

GUY'S.

E. Graham-Smith, b Drake	6
K. V. Trubshaw, c F. J. Nightingale, b Morrison	9
R. C. Poyser, run out	2
S. C. Bowle, c F. Nightingale, b Drake	4
H. M. Langdale, b W. A. Windsor	23
G. T. Willan, b W. A. Windsor	46
H. R. Grellet, b F. C. Morrison	0
H. A. Dennant, c & b W. A. Windsor	16
H. W. Bush, b W. A. Windsor	10
C. M. L. Cowper, c Drake, b Windsor	12
E. W. Strange, not out	10
Extras	9
Total	147

GUY'S v. WESTMINSTER.—INTER-HOSPITAL CUP TIE.

Played on Monday, June 5th, on St. Bart's. ground at Winchmore Hill. Trubshaw won the toss and decided to bat. The wicket played very queerly, having evidently been watered too freely; we began very badly, losing Graham-Smith and Brydone for 9 runs. Trubshaw and Poyser looked like making a good stand, when the former was caught from a poor stroke with the score at 46. The scoring was very slow, and the wicket did not improve; Langdale and Poyser put on 20 runs, 3 wickets then fell quickly, Poyser having played well for 32. Things looked bad with 6 wickets down for 88; Willan and Bush stayed together till lunch. Afterwards the wicket was a little easier, but runs came slowly, Bush was bowled after batting very steadily for an hour for 12 runs. Grellet, through an unfortunate mistake, was run out. With Cowper in, the score reached 150, and at 173 Willan was out for a useful innings of 54, having batted an hour and three-quarters. Cowper made 20 in good form, and the innings closed for 183. The Westminster fielding was keen, and Harvey and Nimmo bowled well, taking four wickets each for 47 and 52 runs respectively.

Bunting and Nimmo started batting for Westminster, but in Graham-Smith's first over, the former played on before a run had been scored; 50 went up for two wickets, and Strange went on to bowl for Graham-Smith. At 52, Trubshaw bowled Crowther, and with his next ball yorked Harvey; Strange then bowled Cooke, who had hit up 19 very quickly, and in the same over got Skey lbw. Coombs was well caught by Cowper off Trubshaw, and then Strange clean bowled the last three men for only 9 runs, giving us a victory by 97 runs. Strange took five wickets for 28 runs, and Trubshaw four for 25.

As Charing Cross have scratched, we meet St. Thomas's in the second round. The match has been fixed for Monday, June 19th, and will be played at Chiswick. Scores:—

GUY'S.

E. G. Graham-Smith, c Harvey, b Nimmo	4
J. M. Brydone, b Harvey	0
R. C. Poyser, b Harvey	32
K. V. Trubshaw, c Bunting, b Nimmo	21
H. M. Langdale, b Harvey	18
S. C. Bowle, c & b Harvey	0
G. T. Willan, b Cooke	54
W. H. Bush, b Nimmo	12
H. R. Grellet, run out	7
C. M. L. Cowper, c Hulseberg, b Nimmo	20
E. W. Strange, not out	0
Extras	15
Total	183

WESTMINSTER.

W. C. Nimmo, c Poyser, b Trubshaw	16
G. T. Bunting, b Graham-Smith	0
S. M. Crowther, b Trubshaw	14
S. G. Cooke, b Strange	19
R. G. Harvey, b Trubshaw	0
H. R. Coombs, c Cowper, b Trubshaw	5
J. E. Skey, lbw, b Strange	0
E. C. Hulseberg, not out	13
F. D. Martin, b Strange	0
C. H. F. Bailey, b Strange	0
C. H. W. Hughes, b Strange	3
Extras	16
Total	86

GUY'S v. ASHBY-DE-LA-ZOUCH.

Played at Honor Oak Park, Saturday, June 10th. This was our first match at home for over a month, and Harris had prepared a splendid wicket. The visitors, captained by J. H. Joyce, had got a good eleven against us. We won the toss, and Brydone and Graham-Smith at once scored freely. In less than forty-five minutes, with the score at 74, Brydone was bowled. The next two wickets fell quickly, and Langdale came in and stayed with Graham-Smith till lunch. Afterwards the score rapidly mounted to 222, when Graham-Smith was unfortunately bowled with only 7 runs wanted to complete his century, his fine score of 93 included 9 fours and 7 threes. Bowle came in, and in spite of numerous changes of bowling, no further wickets fell. At ten minutes past four we declared our innings closed, Langdale having completed his century, which included a five and 8 fours. Bowle hit well for 62. This was our highest score of the season so far. The visitors had a little over two hours to bat, in which time they scored 156 for 4 wickets, and the match was left drawn. German and Francis playing good cricket for 53 and 52 respectively. Scores:—

GUY'S.

E. G. Graham-Smith, b H. W. Joyce	93
J. M. Brydone, b H. W. Joyce	39
R. C. Poyser, b McDonald	10
K. V. Trubshaw, b H. W. Joyce	4
H. M. Langdale, not out	102
S. C. Bowle, not out	62
Extras	37
*Total (4 wickets)	347

* Innings declared closed.

G. T. Willan, A. E. Cawston, H. R. Grellet, C. M. L. Cowper and E. W. Strange did not bat.

ASHBY-DE-LA-ZOUCH.

H. German, c Grellet, b Cowper	53
G. Joyce, c Cowper, b Strange	21
C. A. Checkland, b Strange	9
C. J. Francis, b Graham-Smith	52
S. McDonald, not out	13
Extras	8
Total (4 wickets)	156

W. C. Stevenson, F. A. Barrs, H. W. Joyce, J. H. Joyce, J. Shields and F. C. Stevenson did not bat.

Guy's Hospital Chess Club.

TOURNAMENT, 1899.

Mr. Brailey	played	5	...	won	3
„ Butler	„	2	...	„	0
„ Cohen	„	5	...	„	4
„ Dismorr	„	6	...	„	4
„ Faulks	„	12	...	„	6
„ Kennard	„	13	...	„	9½
„ Kitchin	„	4	...	„	1
„ Mann	„	4	...	„	1
„ Meachen	„	4	...	„	1
„ Pakes	„	8	...	„	5½
„ Parrott	„	7	...	„	5
„ Robinson	„	4	...	„	4
„ Roper	„	4	...	„	1
„ Russell	„	8	...	„	3
„ Tessier	„	2	...	„	0
„ Thomas	„	3	...	„	0

I should like to add that the above list is not complete, as I did not have the results of many of the games.

EDGAR FAULKS, Hon. Sec.

Guy's Hospital Lawn Tennis Club.

GUY'S v. HAROLD.

In glorious weather the first six met the Harold Lawn Tennis Club at Gipsy Hill on Saturday, June 3rd, the result was the defeat of the Hospital by the narrow margin of 5 matches to 4. Mandy and Lacey showed a glimpse of their true form, winning all three matches, but the second and third pairs ought to have annexed more than one match between them. One cannot chronicle the match without reference to the pleasing hospitality of our opponents, and the charming way the Guy's colours in orange-coloured poppies and cornflowers were displayed on the refreshment table—a delicate compliment to the Hospital and team. Result:—

P. S. Mandy and H. K. Lacey beat J. O. Bennett and R. B. Ransford, 6–4, 5–7, 6–7; beat W. R. Ford and A. C. Gibb, 6–1, 6–3; beat G. Colclough and G. W. Vidal, 6–1, 6–3. H. Wacher and L. Cooke lost to J. O. Bennett and R. B. Ransford, 4–6, 1–6; beat W. R. Ford and A. C. Gibb, 2–6, 6–3, 7–5; lost to G. Colclough and G. W. Vidal, 3–6, 2–6. G. G. Cross and E. N. Jupp lost to J. O. Bennett and R. B. Ransford, 4–6, 4–6; lost to W. R. Ford and A. C. Gibb, 7–5, 4–6, 2–6; lost to G. Colclough and G. W. Vidal, 4–6, 3–6.

GUY'S v. HORNSEY.

Played at Honor Oak Park on Thursday, June 8th, at five o'clock. The late start prevented the match being played out, two matches being unplayed. Our opponents turned up one short, so J. M. Brydone played for them. F. C. Wetherell turned out for us for the first time this season and played with Jupp—the combination was a strong one, both men playing near the top of their form. The cold east wind was the only disagreeable element in the match. The Hospital won by 5 matches to 2, 10 sets to 4, or 88 games to 61.

P. S. Mandy and H. K. Lacey lost to E. E. Adamson and H. Broom, 3–6, 9–11; beat R. Hutchinson and L. Tubbs, 6–1, 6–3; beat A. E. Duncan and J. M. Brydone, 6–2, 6–4. F. C. Wetherell and E. N. Jupp beat Duncan and Brydone, 6–1, 6–1; lost to Adamson and Broom, 11–13, 6–4. L. Cooke and H. Wacher beat Hutchinson and Tubbs, 6–2, 7–5; beat Duncan and Brydone, 6–4, 6–2.

GUY'S v. REDHILL.

On Thursday the 8th, Guy's played against the Redhill Lawn Tennis Club, at Redhill. The home team proved too strong, and gained a victory by 6 matches to 3. Result:—

H. K. Lacey and P. S. Mandy lost to Childs and Childs, 3–6, 4–6; lost to Salmon and Powell, 5–7, 4–6; beat Thompson and Thompson, 6–4, 5–7, 6–3. H. Wacher and L. Cooks lost to Powell and Salmon, 3–6, 4–6; beat Thompson and Thompson, 6–1, 6–3; lost to Childs and Childs, 3–6, 0–6. E. N. Jupp and F. G. Cross beat Thompson and Thompson, 6–4, 6–0; lost to Childs and Childs, 1–6, 2–6; lost to Salmon and Powell, 1–6, 4–6.

GUY'S 2ND v. GIPSIES' 2ND.

The second team made its début under most unfavourable conditions at Stamford Hill on Wednesday evening, May 24th. There was a drizzle most of the time, the ground, and very soon the balls, were sodden, the sky was overcast, and the light accordingly very bad, and Manser, Rowland and Ransford were amongst the absentees. The Gipsies', however, under any conditions are far better players than ourselves and the only match worthy of the name was that between our second and their third pair, which was drawn at one set all. In this match Pye-Smith and Wedd played a very good game all round. They have a pretty style, and at the same time do not sacrifice points for the sake of show, as many pretty players are tempted to do; with practice they will make a good pair. They were beaten by the Gipsies' second pair, however, at 3–6, 3–6. H. P. Wiltshire and F. E. Fremantle (capt.), lost to the Gipsies' first pair 2–6, 4–6, and to their second pair 0–6, 4–6. —. Ring and —. Winkworth lost to the Gipsies' third pair 0–6, 2–6, and their first pair 1–6, 2–6.

Appointments.

CIVIL.

STEVENS, T. G., M.D., B.S., Lond, F.R.C.S. Eng., M.R.C.P. Lond., has been appointed Assistant Physician to the Hospital for Women, Soho Square, W.

WARNER, PERCY, L.R.C.P. Lond., M.R.C.S. Eng., has been appointed Honorary Physician to the Woodford Cottage Hospital.

NAVAL.

Staff-Surgeon E. H. WILLIAMS, is promoted to be Fleet-Surgeon in Her Majesty's Fleet.

Surgeon LAWRENCE BIDWELL, has been appointed to the *Lion*, for disposal; and Surgeon E. S. TUCK, to the Royal Naval Hospital, Hong Kong.

Birth.

GROVE.—On June 12th, at Saint Ives, Huntingdonshire, the wife of W. Reginald Grove, M.B., of a daughter.

Marriage.

REYNOLDS—COLLINS.—On the 3rd inst. at Christ's Church, Ealing, Bernard Gore Reynolds, M.R.C.S. Eng., L.R.C.P. Lond., third son of Ellis Reynolds, Esq., of The Poplars, Roydon, near Diss, Norfolk, to Ethel Alexandrine, second daughter of Edward Collins, Esq., of Cumberland Park, Willesden.

Death.

CROOKE.—On May 30th, at King's Heath, George F. Crooke, M.D.

ED.—H. L. E.

Contents.

	PAGE
SARCOMA OF THE STOMACH: Clinical Lecture by Dr. Shaw	261–267
HOSPITAL NEWS	268–270
THE AXILLARY BREAST	270–271
NURSING NEWS	271
CHAPEL NEWS	272
NURSING NOTES	272
PASSIM	273–274
NOTICE	274
ACUTE INFECTIONS DUE TO UNSOUND MEAT: By Herbert E. Durham, M.A., M.B., F.R.C.S.	275–277
IN LIGHTER VEIN	278–279
CONCERT IN THE COURT ROOM	279
APPOINTMENTS	279–280
PASS LIST	280–281
SPORT: Guy's Hospital Athletic Club. Cricket—Past v. Present; Guy's v. St. Thomas's—Inter-Hospital Cup Tie; Guy's v. Eastbourne. Guy's Hospital Lawn Tennis Club—Past v. Present; Guy's v. St. Bart.'s; Guy's v. Chiswick Park; Guy's 2nd v. Gipseys' 2nd. Guy's Hospital Bicycle Club. United Hospitals' Rifle Association v. Honorable Artillery Company	281–284

Calendar of Coming Events.

July, 1899.

Sat. 1.—October Appointment List opened.
G.H.C.C., I., Reigate Priory, home.
II., New Lyric, away.
G.H.L.T.C., I., Chiswick Park, away.
II., St. George's Hospital, home.

Mon. 3.—First Part of the Conjoint D.P.H. Examination

Tues. 4.—Applications to Medical Office for Schedules for First Conjoint Examination to be made not later than this date.
Final Conjoint Examination begins.

Wed. 5.—1.15 p.m., Clinical lecture by Dr. Washbourn.

Thur. 6.—Messrs. Davies-Colley and Symonds take in. Dressers, E. T. Jensen and F. A. Segreda; Clinical, A. H. M. Saward.
G.H.S.C.U., Address by Dr. Pye-Smith.

Fri. 7.—Prize Day, Distribution of Prizes by Mr. Robert Gordon.

Sat. 8.—G.H.C.C., I., Brentwood, home.
II., Merchant Taylors, away.
G.H.L.T.C., I., Harold, home.
G.H.L.T.C., II., St. Thomas's Hospital, away.

Mon. 10.—Intermediate M.B. Lond. Examination begins. Second Part of the Conjoint D.P.H. Examination.

Wed. 12.—1.15 p.m., Clinical lecture by Dr. Washbourn.

Thur. 13.—Messrs. Lucas and Lane's take-in; Dressers, F. G. Cross and D. G. Greenfield. Clinical, A. E. Clarke.
G.H.S.C.U., Special Meeting, Student speakers.
1.15 p.m., Clinical lecture by Mr. Dunn.

Mon. 17.—Preliminary Scientific M.B. Lond. Examination begins.

Mon. 24.—Examinations for Junior and Senior Prizes for General Proficiency and for the Beaney Prize in Pathology.

Tues. 25.—First Conjoint Examination begins. Lectures cease.

Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well a subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

The charge for binding in blue, with the Arms of the Hospital in gold will be ONE SHILLING AND SIXPENCE.

Guy's Hospital Gazette,

JULY 1, 1899.

Sarcoma of the Stomach.

CLINICAL LECTURE BY DR. SHAW.

May 31st, 1899.

GENTLEMEN,—I propose to-day to discuss with you a subject which is one, perhaps, rather of pathological than of clinical interest. The clinical aspects of the case are not very familiar to me, because I did not take charge of the patient until he was in extremis; I only saw him the day before he died, and the interest of the case came to me when I saw the post-mortem examination, specimens from which I propose to show to you to-day. However, I think we can make something out of the clinical features of the case as well as the pathological, and I will begin by reading the notes of the history made by Mr. Baker.

William B., æt. 27, was admitted for a tumour in the abdomen and wasting. Has lived in a very low-lying and ill-drained part of Kent, where, when he was a child, ague was fairly common. He had it when a schoolboy and describes the attacks quite clearly, but has not had an attack for many years. He has been married seven years and has three healthy children. Has not had syphilis or rheumatism.

Three months ago the patient felt out of sorts and at the same time noticed pain on the left side of the abdomen. Two months ago he noticed a lump in the situation of the pain. Five weeks ago he took to his bed and was laid up at home, and afterwards in St. Bartholomew's Hospital at Chatham. While there he became worse, losing weight rapidly. He originally weighed 10 stone 11 pounds. Ten days before admission to Guy's he weighed 8 stone 13 pounds. He sleeps badly and has

lost his appetite. He has occasionally been sick after food. Bowels are constipated. He gives a definite history of the tumour having grown downwards. He has had neither hæmatemesis nor melæna.

On admission.—He is very pale and thin and in great pain, which is continuous, with occasional exacerbations of a colicky character. A tumour of hard not quite uniform consistence is situated to the left of the umbilicus, extending from the costal margin to within two and a half inches of the pubes, and reaching backwards into the loin but not quite filling it. The outline of the tumour and its areas of partial resonance are shown in the diagram copied from the report upon the blackboard.

An examination of the blood showed that there was one white corpuscle to each one hundred red.

Shortly after admission an exploratory laparotomy was performed which showed that the stomach was involved in the growth. The patient was not sick while in the hospital, not even after the anæsthetic.

The main features of the case, then, are progressive emaciation and a large tumour in the left hypochondriac region.

There was a good deal of difficulty in determining what was the nature of this tumour, and I think I am right in saying that an accurate diagnosis of its situation and nature was not made until the post-mortem examination. Although I did not have an opportunity of discussing the diagnosis of the tumour by the bedside, I may just mention to you what are the possible causes of tumour in the left hypochondriac region. It might have been renal, suprarenal, or splenic, or gastric, or intestinal; or it might have been in the glands, or in the connective tissue. There was evidently before his admission a suspicion that it might have been splenic; I think that is indicated by the stress laid in the report upon the history of malaria from which the patient previously suffered.

Now, with regard to the ways in which you would endeavour to come to a conclusion as to what is the nature of a tumour found in this region. Practically you employ those methods of diagnosis which are common to the diagnosis of all abdominal tumours. You try to ascertain the physical relations of the tumour by putting your hand on it, looking at it, and percussing and palpating it in every direction. By this means you may sometimes be able to tell that a tumour is situated in a certain organ, but often the evidence thus obtained is very indistinct. You will find tumours of such a character that, even by the most careful manipulation and study, based on what other people have discovered to be the special physical relations of abdominal tumours, it is impossible to tell in what organ they are situated.

If the tumour can be pushed up from the loin, and grasped between your two hands, it is probably renal; if it moves very readily on respiration and its dulness passes up into the thorax, it is probably splenic. On the other hand, if it is resonant in front, and shifts its position while you are examining it, or from day to day, then you assume it is in connection with a portion of the alimentary canal which is movable, such as the stomach or the intestine.

I cannot go more fully to-day into the diagnosis by physical relations, but there is another way in which you can make a diagnosis of the tumour you have to deal with, and that is by the existence in the patient of symptoms suggesting involvement of certain organs. For instance, if your patient with abdominal tumour is much affected with vomiting, hæmatemesis, or pain after taking food, you will naturally expect that it is the stomach which is involved; if he has constipation or melæna, it is the intestine; if he has hæmaturia or pus in the urine, it is the kidney; if there is well-marked leucocytosis you will think it is the spleen. If there are no special symptoms indicating the involvement of one of the viscera, you generally come to the conclusion that you have to deal with a tumour situated in the glands or connective tissue.

But apart from localising symptoms of this sort, there are other general considerations about the condition of the patient which should be taken into account. I told you a short time ago, when talking about a case of disease of the cerebellum, that if you can make up your mind absolutely as to the situation of a lesion, you have got half-way to making up your mind as to its pathological character. On the other hand, if you can make up your mind what a thing is, you lessen the possible seats in which it might be situated. For example, from the general history of this patient there could be very little doubt indeed that he was suffering from a malignant growth; emaciation of an extreme degree was rapidly coming on. And knowing that your patient has got a malignant growth, and knowing that it is a large one, you will not be in the least inclined to diagnose that any condition of the spleen is producing it, because we know that large and malignant growths of the spleen are so exceedingly rare as

to be practically non-existant. This, then, is one of the ways in which a knowledge of pathology is of such vital importance to you, a knowledge that is of morbid anatomy. Until you know what are the diseases which may affect an organ, you are not in a position to discuss the nature of the lesion affecting the organ before you. It is for this reason that we are always inviting you to go on a round through the museum, and make yourselves familiar with things that have happened in all parts of the body. It is for this reason that museums should always be arranged in anatomical order instead of in sequence of pathological processes.

But there is yet another mode of diagnosis, one that is becoming daily more popular, and that is, diagnosis by surgical exploration. To "look and see" is easy. It is not, however, always easy to know what you do see when you have looked. Diagnosis by exploration has its limitations very distinctly. For example, if you have got the abdomen open, you can no longer put your finger into the rectum and see what effect might be produced by pressing on the tumour bimanually; and you cannot put your hand behind the patient's loin and push the tumour up; you cannot obtain valuable information from the patient's own sensations. It has sometimes occurred to me, when we have been in doubt as to what a thing is, and have got the surgeon to explore and see, that we have known less about it after exploration than we thought we knew before. Why I am laying stress upon this is because with these improved methods of diagnosis, as they are called, one becomes disposed to neglect what are regarded as the less important, the old-fashioned methods of diagnosis. I want to impress upon you very strongly that before you ever allow an exploratory operation to be performed, you must have exhausted every other means of diagnosis. Can you imagine anything more humiliating than to undertake an exploratory laparotomy, and find some condition which cannot be elucidated owing to the neglect of some simple enquiry or investigation which has been allowed to pass in reliance upon the completeness of the diagnosis about to be made by the surgeon. I want to impress upon you that as each new method of diagnosis comes along, you must not neglect the old methods of diagnosis, but add the new to the old. I may illustrate my point by reference to the use of the stethoscope. If, without due investigation of the patient's history, you rush to your stethoscope in order to listen to the heart and lungs and diagnose in that way, how much less likely you are to arrive at an accurate conclusion than if you have previously used all the methods of enquiry and inspection that the physician has at his command.

Apart from all other means of investigation there is great value in the history of your case. History is a thing which in hospitals you are rather liable to neglect because of the difficulty their is in arriving at an accurate history in the class of patients you have to deal with. It frequently happens that after the ward clerk has made out an elaborate history of a case, the physician asks the patient a few questions and gets an absolute denial of many of the symptoms which the ward clerk has acquired with great pains and labour. This is disheartening. But with regard to the questioning of patients, we ought to be disposed to take a leaf out of the book of the lawyers. What labour they will undergo in order to get at what, from their point of view, is the truth! If we had more of their patience, and employed more cross-examination and re-examination, we might get more accurate information from our patients than we do. But let me repeat that before you allow your patient to submit to any exploratory operation, feel quite sure that you have thoroughly investigated his history, and have made use of every other possible means of diagnosis.

While on the subject of exploratory operations, I should like to make a suggestion with regard to them. It would be wise, perhaps, if we more often used exploratory operations purely for exploratory purposes. I feel sure that I have sometimes seen cases in which, at the end of a long exploratory operation, a therapeutic operation has been performed, and the patient has died, I think, as a result of the extreme length of the operation altogether. I think very often it would be better to explore and try to find out what is the matter with the patient, and then, as soon as this is ascertained, sew up the wound. The therapeutic operation can then be carefully planned and performed at a subsequent date. Often the case is so urgent that delay might be fatal, but when this is not so, we may achieve a better result in this way than by attempting to discover and treat the condition at one prolonged operation.

Now, it was discovered by the exploration of this patient's abdomen that the stomach was involved by malignant growth, and also that any operation for the relief of the condition was quite out of the question. After the operation there was no arrest of the downward progress;

the patient steadily got worse, and died on the ninth day after the operation. At the autopsy we got a little further information; we then saw that he had been suffering from primary malignant disease of the stomach of a most unusually extensive character. It would be interesting to consider with you for a moment how it was that a case of such advanced malignant disease of the stomach was not diagnosed. The symptoms of malignant disease of the stomach may be grouped under three distinct headings. First of all, the symptoms of involvement of the stomach common to most gastric diseases: pain after taking food, vomiting, hæmatemesis. Secondly, what may be called constitutional symptoms: wasting, anæmia. Thirdly, there are local physical signs: tumour, or dilation of the stomach. If you have to deal with a case presenting some symptoms out of each of these three groups, the diagnosis is generally quite simple. But in a majority of cases the diagnosis is not so easy. First, I should like you to remember that a patient may have a very distinct growth in the stomach, and all these symptoms may be absent. I cannot give you a better example of that than by showing you this specimen (museum preparation No. 695). Here is a great growth in the stomach; the pyloric end, the cardiac end, and the whole of the lesser curvature are involved in the growth; great bossy masses are protruding from the lesser curvature. The patient was eighty-one years of age at the time of her death, and she died of acute strangulated hernia, and it was recorded with the utmost confidence that she never suffered from any symptom of gastric disease, or was sick in her life until her hernia became strangulated.

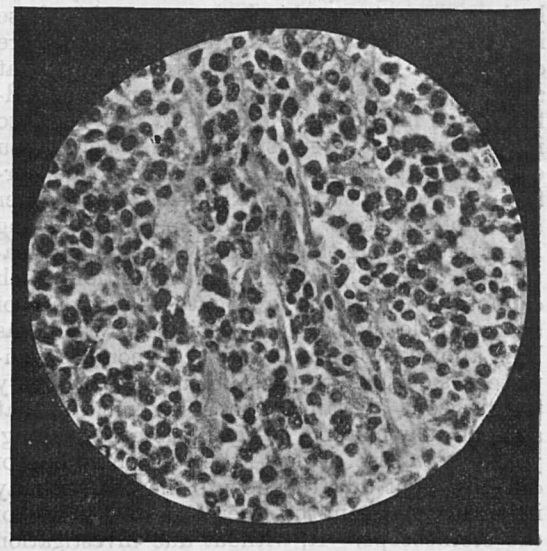
But difficulty in diagnosis is presented when the symptoms are restricted to one of the above groups. It is not uncommon to find patients with carcinoma of the stomach who have no constitutional symptoms and no local physical signs; all their symptoms are those of local gastric disease. In these circumstances it is often difficult to distinguish between carcinoma and other organic diseases of the stomach, such as gastric ulcer or gastritis.

There is again a class of case in which the constitutional symptoms altogether predominate, so that the patient has no local signs of gastric disease at all. Such cases I have seen diagnosed as pernicious anæmia. It is not, indeed, an uncommon thing for patients to have a diagnosis of pernicious anæmia made in the wards, and for malignant disease of the stomach to be found afterwards in the post-mortem room.

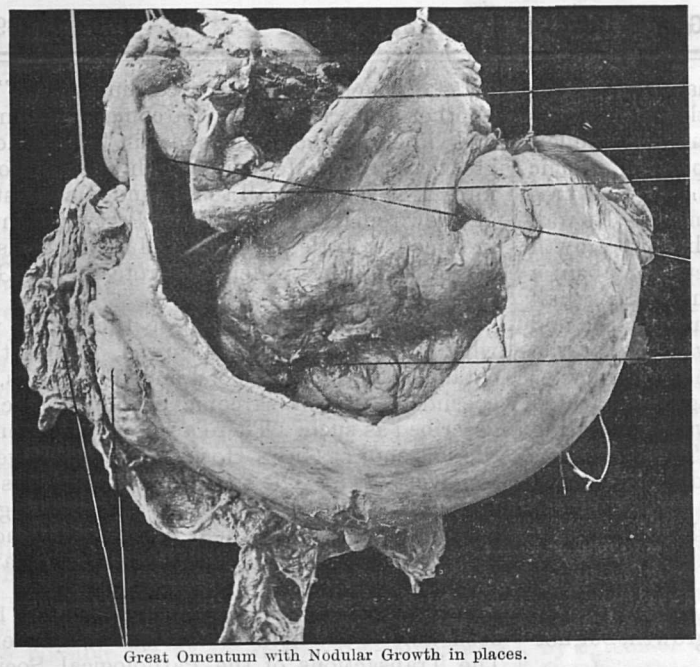
Lastly, there is a class in which there is an obvious tumour, but not sufficient symptoms of gastric disorder to enable you to establish the fact that the growth is involving this organ. Such was the case before us.

I do not propose to say more with regard to the diagnosis of gastric disorders than to remind you of these difficulties. At the same time I would impress upon you the great importance of developing our powers of diagnosis of gastric cancer on account of the recent advances in gastric surgery. It is rather painful for the physician to find himself limping behind the surgeon in powers of diagnosis. I do not say that the surgeon can diagnose more accurately than the physician, but the surgeon can treat the case so much more perfectly than the physician can diagnose it. That always has been so. If we could only tell the surgeon that carcinoma of the stomach existed, in its early stage, the surgeon might successfully remove it; the same applies to many other subjects where medicine and surgery meet. Therefore, it is that, as the surgeon extends his projects into the different departments of pathology, we are stimulated in the endeavour to perfect our diagnosis.

Turning now to the pathological aspect of the case, I would draw your attention to the specimens before you, the features of which are well-shown in the photographs that have been taken by the hospital artist. I cannot better describe



Micro-Photo of Nodule removed at Operation.
Power ⅛inch Objective.



Great Omentum with Nodular Growth in places.

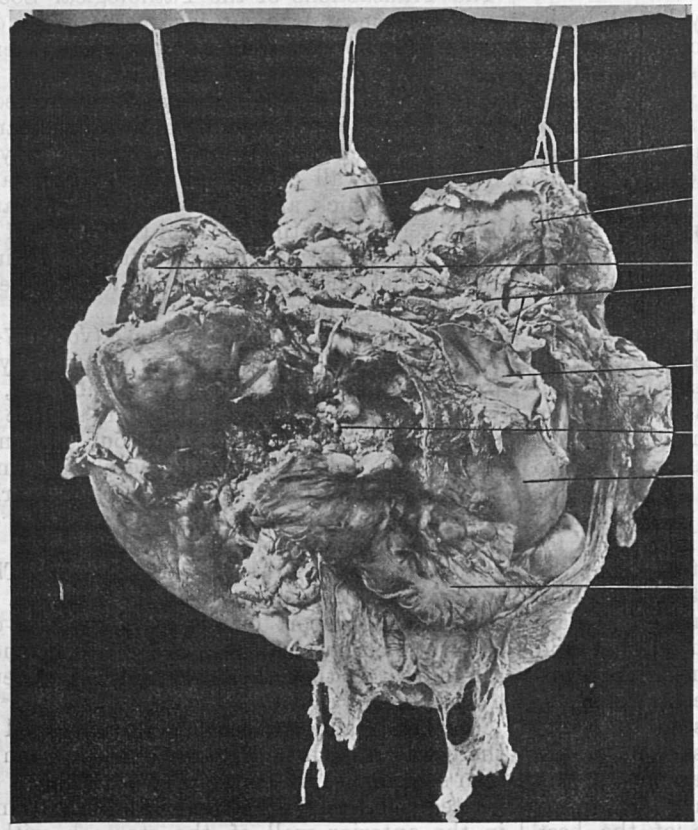
Glands infiltrated.

Spleen.

Thickened Anterior Wall of the Stomach turned upwards.

Pylorus fairly free and without obstruction.

Ulcers (ragged) on Posterior Stomach Wall.



Anterior Stomach Wall drawn up.

Duodenum.

Spleen, with large secondary growth.

Head of Pancreas ? with secondary growth.

Aorta, laid open.

Glands, with growth.

Posterior Wall of the Stomach.

Transverse Colon adherent to growth at splenic flexure, but not involved.

PHOTOGRAPHS OF LARGE DIFFUSE GROWTH OF STOMACH, WITH SECONDARY GROWTHS IN SPLEEN, PANCREAS AND GLANDS.

Weight of Stomach, with Spleen, Pancreas and Glands = 9½ lbs. Growth in the Stomach, 13 inches long. Wall an inch thick in places.—(*Vide* Dr. Shaw's Lecture.)

the features of this specimen than by reading the notes made by Mr. Fremantle at the post-mortem. "The stomach is adherent to the left lobe of the liver, to the spleen, diaphragm, splenic flexure of the colon and pancreas. It measures thirteen inches in its longest diameter. Its wall is infiltrated with soft white malignant growth throughout its whole extent, except for about a square inch near the pyloris. The wall is half an inch thick over the anterior surface, and thicker behind and on both curvatures, at the fundus reaching as much as one and a quarter inch in thickness. There is a ragged ulcerated surface all over the posterior wall, measuring eight inches in each direction. The ulceration is nowhere very deep. In the duodenum one inch from the pylorus (which is unaffected), is an opening surrounded by growth leading into an abscess cavity passing behind the stomach. This is apparently an invasion of the duodenum from without.

"The colon is adherent to the growth, but not invaded.

"There are masses of secondary deposit in the omentum, in the head of the pancreas, and in the neighbouring lymphatic glands. The spleen contains a large mass of growth which appears to be an extension of the growth in the stomach. The mass consisting of the stomach, pancreas, and spleen, with adherent secondary growths, weighs nine and a half pounds."

This was the state of affairs as found at the post-mortem examination. As the result of histological sections made by Mr. Dunston, microphotographs of which have been prepared by Mr. Baker, the diagnosis is sarcoma of the stomach, and there, if you please, lies its great interest, for sarcoma of the stomach is exceedingly rare. When I came across this specimen and decided it was sarcoma, I thought at once that that would be a useful case on which to give a clinical lecture to you. I thought I knew a little about sarcoma of the stomach, and should be able to extend my knowledge for your benefit. But when I came to look up the subject I found how little the text-books had to tell about it. I found that during the last twenty years at Guy's Hospital, in ten thousand post-mortem examinations, only one case of primary sarcoma of the stomach has been recognised, or at least indexed. There was in the same period one secondary growth of sarcoma of the stomach. No case of primary sarcoma of the stomach has been recorded in the Clinical Society's Transactions. In one of the best modern books, running into eleven hundred pages, all that is said of the subject is, "Sarcomata of the stomach are exceedingly rare." In another book it says: "Sarcomata, fibromata, and lipomata sometimes occur." In another great system of Medicine which bids fair to run into eight volumes, all that I find is an abstract of a few remarks made by Dr. Perry and myself in a modest little paper on "Malignant Disease of the Stomach," which we wrote in the Guy's Hospital Reports, in 1891.

As a further indication of the rarity with which the disease is recognised, out of three catalogues of museums of London hospitals, one specimen only of sarcoma of the stomach is described as such. There are four specimens in the museum at Guy's Hospital, and now we are to have a fifth. The specimens in the museum at Guy's Hospital I will not refer to at great length. You know them; if you do not I hope you will soon make their acquaintance. Their numbers are 718 to 721.

But there are three specimens that I have been able to get hold of through the Index of The Transactions of the Pathological Society, and I thought I might just very briefly draw your attention to them. First of all, there is Dr. Cayley's case (Vol. 1869, p. 170). This was a man, aged 57; the growth affected all the stomach except the pyloric and the cardiac ends, the weight of the stomach was thirty-five ounces, the wall of the stomach was two and a half inches thick, and there was much ulceration. It is very interesting to read the report of this case, because it was quite clear from the clinical report that the case was considered to be one of splenic leucocythæmia.

Then there is Dr. Legge's case (vol. 1874, p. 120), a girl 17 years of age, in which only the pyloric half of the stomach was affected, the wall being two inches thick. The surface was ulcerated, a condition which our specimens mostly do not show, and there were many secondary deposits. It is said to be the earliest case of malignant disease of the stomach ever recognised. One of the specimens on our shelves is from a girl two years younger. There was well-marked leucocytosis in this case. In Mr. Baker's report of our patient of to-day, the white corpuscles were to the red as one in a hundred, so that there was also slight leucocytosis in this case.

In Dr. Hadden's case, a woman aged 53, there was a rather different condition from our own specimens, and from the two I have just related. There was a localised nodular tumour in the anterior wall of the stomach with an ulcer in it. There was no vomiting in the case at all. Here again there was leucocytosis.

I perhaps might condense the information gained from a study of these eight cases for you in a more systematic manner, but, first of all, I should like to discuss with you whether the rarity of sarcoma of the stomach is as great as is indicated by the few specimens accessible. I think it is unlikely There is no doubt that when a particular form of growth is very rare there is a tendency to assume that a specimen about which there is any doubt belongs to the commoner form. A large number of malignant growths of the stomach are not submitted to microscopic examination, and from the fact that the naked-eye appearances of sarcoma of the stomach are not very different from the ordinary malignant growth, a good many cases of sarcoma may be overlooked. Perhaps you will prove this to be true by sending me a few more specimens of sarcoma of the stomach for the museum.

It would be interesting to know whether it were possible for us to diagnose a sarcoma of the stomach during life. I should like, first of all, to draw your attention to the rarity with which the mucous membrane is destroyed in sarcoma. In all the four specimens we have in the museum there is a remarkable freedom from the involvement of the mucous membrane. The mucous membrane is stretched over the growth, and smooth. Perhaps this is the reason that hæmatemesis seems to be rare in sarcoma of the stomach.

Now we come to a feature in sarcoma which is true in every part of the alimentary canal as well as the stomach, namely, that there is little tendency to contraction. In a case of sarcoma of the small intestine, the lumen of the bowel is considerably increased by the sarcoma infiltrating its walls. With carcinoma it is different: the wall of the intestine looks as if a piece of string had been tied round it. There is no tendency in sarcoma to contract the stomach either generally or at the pylorus. And because sarcoma does not contract the pylorus, one of the great causes of vomiting is removed. Vomiting has certainly not been a very prominent feature in most cases.

Another feature which comes out very well in most specimens is that the muscle is seriously involved by sarcoma, in opposition to what is found in carcinoma. In carcinoma of the stomach, if you make a section through the wall you often see the subjacent muscle hypertrophied, but looking quite normal and healthy. In sarcoma of the stomach the muscle is generally infiltrated deeply. What is likely to be the result of that infiltration? The involvement of the muscle, you would have thought, would have prevented the muscle sending the food along, but we do not find in sarcomata that the vomiting is more extreme than in carcinomata.

Another feature of nearly all these sarcomata is the large size of the tumour; it grows very rapidly and reaches a very considerable size. In most of the cases the patient has presented a definite tumour.

There is another peculiarity of sarcomata which is borne out by two of these specimens, but not by the others. One of the most striking things about carcinoma is that you may have the entire stomach involved, the growth may extend absolutely to the pyloric ring, and then the moment you pass into the duodenum the wall is normal; there is a very striking tendency for carcinoma of the stomach to cease at the pylorus. I have hardly ever seen a specimen in which the duodenum was directly involved by extension of carcinoma through the pylorus. On the other hand, in two of these specimens there is a sarcomatous growth involving the stomach and the first two inches of the duodenum. It does not seem probable that this would give rise to any special symptom.

We come now to the last and most marked feature, the age of the patient. The ages of the four patients whose histories are recorded in the museum catalogue were fifteen, eighteen, thirty-eight and sixty-seven. The additional cases which I have brought to your notice to-day do not make any difference to the ages at either end; seventeen is the youngest of the additional ones, and fifty-seven is the oldest. In sarcoma of the stomach, as in sarcoma everywhere, the patients are likely to be young. The average age of patients with carcinoma of the stomach is about fifty-two. The youngest case of carcinoma in the cases Dr. Perry and I tabulated for our paper was thirty-two; the youngest case of sarcoma was fifteen; one half the cases of sarcoma were younger than the youngest case carcinoma. The youth, therefore, of the patient is a striking thing in sarcoma, and if you are dealing with a patient under thirty who has got malignant disease of the stomach, it will be reasonable to assume that you are dealing with a case of sarcoma.

From the Gazette's Special Pathologist.

T. H., REIGATE.—No tubercle bacilli can be found in the sputum.

H. V. R., FORDINGBRIDGE.—No tubercle bacilli could be found in the sputum. PATHOLOGIST.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

CASES UNDER DR. PYE-SMITH.

MARY 25, 33. Exophthalmic goître.
26. Acute rheumatism.
28. Acute rheumatism. First attack. Mitral regurgitation.
29. Empyema. Operation.
37. Mitral regurgitation.

PHILIP 21. Mitral stenosis and incompetence. Independent chronic interstitial nephritis.
23, 35. Tuberculous peritonitis.
24. Acute rheumatism. Mitral stenosis and incompetence. Aortic incompetence.
26. Mitral and aortic disease. Both obstruction and regurgitation.
28. Aneurysm of ascending aorta and innominate.
30. Progressive muscular atrophy.
31. Malignant growth of colon. Colotomy.
36. Hypertrophied and dilated heart. ? Alcohol.
37. Acute nephritis.
38. Chorea. Apical systolic bruit.
40. Carcinoma ventriculi.

CASES UNDER DR. TAYLOR.

MARY 38. Neuritis.
39. Empyema.
40. Exophthalmic goître.
42. Ascites.
43. Bronchitis.
44. Appendicitis.
45. Anæmia.
46. Rheumatism.
47. Duodenal ulcer.
48. Gastric ulcer.
49. Pneumonia. Right base.
50. Chorea.

STEPHEN 1. Broncho-pneumonia.
2. Fluid at right base.
3. Pneumonia. Right lung.
4. Acute rheumatism.
5. Thoracic abscess.
6. Bright's disease.
7. Ascites.
8. Osteo-arthritis.
9. Diabetes.
10. Pneumonia. Recovering.
11. Acute Bright.
12. Bright's disease.
13. Lead poisoning.
14. Recurrent appendicitis.

STEPHEN. 15. Abdominal tumour.
16. ? G. P. I.
19. Locomotor ataxy.
20. Chronic dyspepsia. ? Malignant growth

CASES UNDER DR. HALE WHITE.

PHILIP 1. Sciatica.
2. Appendicitis. Operation.
3. Right facial paralysis.
4. Aortic regurgitation and stenosis. Mitral regurgitation.
5. Dilated tubes. ? Phthisis.
6. ? Gall-stones. ? Growth.
7. Pneumonia. Crisis seventh day.
8. Dilated heart. ? Granular kidneys.
10. Hodgkin's. Chylous ascites.
12. Growth. ? Stomach.
15. Phthisis.
16. Osteo-arthritis. Aortic systolic bruit.
18. Rheumatic fever. Relapse.
19. Pleuritic effusion. Aspirated.

MARY 13. Chorea.
14. Gastric ulcer.
15. Apical pneumonia. Bronchitis.
17. ? Typhoid.
18. Leucocythæmia.
20. Chronic Bright.
22. Cerebral tumour. Operation.
23. Appendicitis.

CASES UNDER DR. PITT.

MARY 1. Mitral stenosis and incompetence,
2. Enteric fever.
3. Acute rheumatism.
4. Acute rheumatism.
5. Mucous colitis.
6. Appendicitis. Operation.
9. Acute eczema.
10. Pyrexia.
11. Mitral stenosis. Tricuspid incompetence Paracentesis abdominis.

STEPHEN 21. Glycosuria with peripheral neuritis.
22. Empyema.
24. Tuberculous peritonitis.
25. Pneumonia, basal
26. Pneumonia, basal. Anti-pneumococcin.
30. Pneumonia, apical. Anti-pneumococcin.
31. Eczema, acute.
34. Chorea.
35. Pericarditis.
36. Cerebral hæmorrhage. Pons,
37. ? Pneumonia. Emphysema.
40. Locomotor ataxy.

"Clinical."

2. Locomotor ataxia. Gastric crise
3. Suppurative peritonitis. Operation. Recovery.

4. Malignant growth of liver.
5. Cerebellar tumour. Operation.
6. Perinephric abscess. Operation.
7. Empyema. Resection.
8. Œsophageal constriction. ? Irritant poisoning.
9. Perforated gastric ulcer. Operation. Recovery.
10. Acute myelitis.
11. Empyema. Operation.
19. Aortic regurgitation and stenosis. Mitral regurgitation.
20. Mitral stenosis and regurgitation. ? Aortic stenosis.
21. Pericarditis. Mitral disease.
22. Lobar pneumonia.
23. Phthisis.
26. Cerebellar tumour.
27. Mitral stenosis and regurgitation. Tricuspid regurgitation.
28. Suppurating hydatid of liver. Pneumo-hepatic fistula.

In the Surgical Wards.

Cases under Mr. Howse.

NAAMAN
5. Tuberculous tarsus. Scraped.
6. Hæmatocele. Incised and drained.
8. Spinal caries. Gluteal abscess. Incised.
9. Stricture and cystitis.
10. Carcinoma recti. Inguinal colotomy.
11. Enlarged prostate.
12. Sarcoma of foot. Stokes-Gritti amputation.
13. Recurrent appendicitis with abscess and retention. Abscess incised.
14. Recurrent supra-orbital epithelioma.
16. Osteo-arthritis of knee. Explored and washed out.
17. Multiple painful lipomata.

DORCAS
1. Æt. 4. Fractured femur. Double Bryant.
3. ? Renal calculus.
4. Hip disease.
5. Paralytic talipes equinus.
6. Bullet in skull. Extracted.
7. Recurrent carcinoma mammæ. Excised.
8. Carcinoma mammæ. Excised.
9. Tuberculous knee. Excised.
10. Ankylosed flexed knee. Excised. Lupus hypertrophicus of face.
13. Fractured femur. Hodgen.
14. Sinus after Furneaux-Jordan.
15. Syphilitic arthritis of knee. Amputation through thigh.
16. Double hip-disease. Ankylosis.

Cot A. Mastoid abscess.
B. Spinal caries.
C. Vesical calculus.

ASTLEY COOPER
5. Dislocated elbow.
9. Supra-condylar fracture of femur.

Cct. Fractured base.

Cases under Mr. Davies-Colley.

JOB
1. Strangulated inguinal hernia. Kelotomy.
2. Nævus on foot. Excised.
3. Epithelioma of lip. Excised.
4. Spinal caries with sinus.
5. Tuberculous knee. Excised.
6. Tuberculous knee.
7. Tuberculous tarsus. Scraped.
8. Iliac abscess.
10. Lipoma in posterior triangle. Excised.
11. Sacro-coccygeal congenital tumour. Excised.
12. Lumbar abscess. Incised.
20. Cleft palate and hare lip. Cheiloplasty.
21. Tuberculous ankle. Syme.
25. ? Chondroma. ? Chondrosarcoma of ribs. Excised.

LYDIA
1. Gummatous ulcers on leg.
2. Tuberculous shoulder. Incised.
3. Fractured os calcis.
5. Strangulated umbilical hernia. Kelotomy.
6. Hydatid of liver. Drained.
7. Concussion with cerebral irritation.
12. Sublingual exostosis.
13. Caries of lower jaw. ? Dental.
14. Intracapsular fracture of neck of femur. Hodgen.
15. Umbilical hernia. Radical cure.
17. Carcinoma mammæ. Breast excised.
18. ? Renal calculus. Nephrotomy.

Cot A. Fractured femur. Vertical suspension.
C. Strangulated inguinal hernia. Reduced.

CORNELIUS
4. Fractured femur. Liston's splint.
12. Fractured pelvis.
17. Fractured femur. Hodgen.

Cases under Mr. Lucas.

LAZARUS
1. Recurrent sarcoma of crureus. For Coley's fluid.
3. Stricture of œsophagus.
4. Myxo-adenoma of parotid. Excised.
5. Epithelioma of lip and secondary suppurating glands.
16. Mastoid abscess. Antrectomy.
17. Mastoid abscess. Antrectomy.
18. Genu valgum. Macewen's osteotomies.
19. Epithelioma of cheek on scar of lupus erythematosus. Excised.

MARTHA
1. Bullet wound in neck. Extracted.
2. Carcinoma mammæ. Excised.
3. Carcinoma mammæ. Excised.
5. Tuberculous elbow. Excised.
6. Cerebral abscess. Trephined and drained
7. Old tuberculous knee. Excised.
14. Tuberculous tarsus. Pirogoff.

Martha	15.	Cystic breast.
	16.	Compound fracture of tibia and fibula.
	18.	Bullet wound in head.
	19.	Bullet in brain. Extracted.
	20.	Cystic bronchocele. Partial excision.
	21.	Calculous pyonephrosis. Nephrolithotomy.
Cot A.		Median cervical dermoid.
B.		Rachitic tibial osteotomies.
D.		Fractured femur.
Astley Cooper	12.	Fractured olecranon.
	15.	Fractured patella.
	22.	Fractured femur.
	31.	Spinal concussion.
Cot.		Fractured femur.

Cases under Mr. Golding-Bird.

Luke	6.	Movable kidney. Nephrorraphy.
	8.	Papillomata of rectum. Excised.
	10.	Urinary fistula and stricture.
	11.	Irreducible inguinal hernia.
	12.	Enlarged prostate.
	13.	Stricture with retention.
	14.	Mastoid abscess. Antrectomy.
	16.	Sarcoma of neck. Excised.
	17.	Mastoid abscess.
	18.	Charcot's hip.
	19.	Tuberculous shoulder-joint.
	20.	Gonorrhœal synovitis of knee.
	21.	Tuberculous elbow.
Charity	2.	Calculous pyonephrosis. Nephrolithotomy.
	4.	Umbilical hernia. Radical cure.
	6.	Tuberculous ankle. Syme.
	8.	Sarcoma of buttock. Excised.
	9.	Ruptured urethra.
	10.	Lipoma of buttock. Excised.
	11.	Pott's fracture.
	12.	Fractured patella.
	14.	Sarcoma of femur. Amputation through thigh.
	16.	Foreign body (½d.) in intestine.
	17.	Appendicitis. Appendicectomy.
Cot A.		Hare-lip and cleft palate. Double.
B.		Psoas abscess and Pott's disease.
Astley Cooper	10.	Fractured patella.
Cornelius	9.	Fractured femur.
	10.	Fractured femur.
	13.	Fractured femur.
	20.	Pott.

Cases under Mr. Jacobson.

Naaman	19.	Dislocation of first metacarpo-phalangeal joint. Resection.
	21.	Chancre with phimosis. Circumcision.
Dorcas	19.	Right reducible inguinal hernia.
	20.	Tuberculous cervical adenitis. Excised.
	21.	Trigeminal neuralgia.
	22.	Congenital talipes varus.
Cot D.		Rachitic tibiæ.

Cases under Mr. Symonds.

Job	13.	Stricture. External urethrotomy.
	14.	Bronchocele. ? Malignant.
	15.	Gummatous periostitis of clavicle with dislocation.
	17.	Sarcoma of soft palate. Supra tonsillar fossa.
	18.	Carcinoma laryngis. Tracheotomy.
	19.	Lympho-sarcoma of fauces with glands involved. Coley's fluid.
Lydia	20.	Œsophageal stricture. Gastrostomy.
	22.	Carcinoma recti. Excised.
Ruth	26.	Occlusion of larynx. Post scarlatinal.
	35.	Nasal polypi. Frontal sinus empyema.

Cases under Mr. Lane.

Lazarus	11.	Hypospadias and undescended testes. Plastic operation.
	13.	Cystitis.
Martha	10.	Tuberculous kidney.
	13.	Hydatid of liver. Drained.
Cot C.		Old necrosis of femur. Bone transplanted.

Cases under Mr. Dunn.

Luke	1.	Epithelioma linguæ glands. Glands excised.
	3.	Tuberculous knee.
	4.	Tuberculous knee.
Charity	20.	Appendicular abscess. Incised.
	21.	Recurrent appendicitis. Appendicectomy.
	22.	Umbilical hernia. Radical cure.
Cot D.		Nævus on face.

The Axillary Breast.

An interesting case of this abnormality was recently recorded in the Brit. Med. Journal.* A primipara, aged 28, came under observation for a swelling in the right axilla which formed five months after delivery, during the period of lactation. The swelling gradually enlarged and gave rise to a secretion which had the microscopical characters of milk. The swelling was situated just behind and beneath the anterior fold of the axilla, and was quite separate from the normal right breast. No nipple or areola existed, but there was a minute pore in the skin over the swelling from which a milky secretion could be squeezed. After weaning the child, the lump in the axilla gradually diminished in size, but did not entirely disappear.

This account reminds me of a case that we had in Queen Ward last Christmas. The woman (aged 23) was admitted for induction of labour on account of contracted pelvis. The child was very feeble, and survived its birth only a few hours. On the second day of the puerperium the breasts became swollen and very tender, and the

* Templeton, Brit. Med. Journ., 1899, vol. I., p. 1089.

following day a lump was found in the right axilla. It was situated upon the outer or brachial wall of the axilla near the apex, and was the size and shape of a walnut. The skin over it was intimately adherent, and the swelling projected from the surface like a distended sebaceous cyst. It was painful to touch, and the skin there was reddened. No nipple or areola could be found, but a little watery secretion had oozed from the skin and stained her linen. No similar swellings were present in the opposite axilla, but a supernumerary nipple and areola were found upon the left breast, vertically below the normal structures. Three days later the breasts and the right axillary tumour had considerably diminished in size, and were no longer tender. At the end of a fortnight the lump had disappeared. It was regarded as an example of "Champneys' gland."

Three forms of axillary breasts have been described. The commonest is an accessory lobule of the pectoral gland, which has more or less lost its connection with the parent structure and became sequestrated. Such a breast has no proper nipple and areola, though it usually secretes through ducts in the overlying skin. The tumour in the first case mentioned above probably belongs to this class: a true mammary gland provided with an areola and a functional nipple, and would seem to be a very rare occurrence within the confines of the axilla, though supernumerary pectoral breasts are better known. The third variety of axillary swelling is that described by Dr. Champneys and Mr. Bowlby, and in their latest communication on the subject* they have shown that these lumps consist of hypertrophied specialized sweat-glands which occur in the normal integuments of the axilla, and are known as Sappey's glands. They are usually described as situated at the apex of the axilla, but probably they have a wider distribution, and in our case the swelling was distinctly on the *outer* wall of the axilla, though near its apex.

These axillary swellings have more than an obstetric interest, for they may become the seat of new growths. I have examined several examples of fibro-adenomata and carcinomata which were removed from the axillary space, and seemed to have no connection with the adjacent mammary gland. Yet in structure these tumours were indistinguishable from those met with in the breast itself, and further confirmation was found in the existence of normal glandular lobules at the periphery of these new growths.

There can be little doubt, too, that Sappey's glands may be the seat of primary carcinomata in the axilla. Indeed Dr. Creighton and Mr. Paul † have described such growths, and I have seen at least two specimens which would bear no other interpretation. The characteristic feature, apart from the situation and relations of the tumour, is the presence of a layer of unstriped muscle fibres beneath the epithelium. And this muscle may be recognised not only beneath the epithelium of the ducts and acini of the unabsorbed portions of Sappey's glands, but around the smaller cancerous alveoli, at the growing edge of the tumour.

In the central parts of the tumour I have not found these muscle fibres, as they doubtless become destroyed in the process of growth. In the course of the examination of more than a thousand tumours of the breast I have not met with this appearance in growths from the mammary gland proper. The axillary lumps which bear Dr. Champneys' name possess, therefore, a direct surgical interest, for, if they do not disappear with the cessation or during the course of lactation, the possibility of the subsequent development of malignant disease must be borne in mind.

Lastly, I would call attention to the occurrence of carcinomata in the axilla, which, though apparently primary, are in reality metastatic growths. Some remarkable instances of this have come under my notice, one of which was especially interesting. The patient was a middle-aged woman with a tumour within the confines of the right axilla, but no other superficial growth was discovered. Histologically the tumour proved to be a columnar-celled carcinoma, of the villous type, yet unlike that which developes in the breast. The stroma of the growth contained numerous concentric calcareous granules, or psammoma grains, such as are found in ovarian tumours, and I ventured the opinion that the axillary tumour was secondary to a carcinoma of the ovary. Enquiry elicited the fact that ovariotomy had been performed about a year and a half previously for what was regarded as a simple ovarian cyst. Pelvic examination now revealed the presence of a small hard mass, which steadily enlarged, and proved fatal about ten months after the removal of the axillary carcinoma.

J. H. TARGETT.

*Med. Chi. Trans., vol. 78, p. 267, 1895.

†Trans. Path. Soc. 1895, vol. 46, p. 153.

Nursing News.

THE two Sisters whose appointments to posts outside the hospital we recorded last week, will be leaving us on July 1st and July 4th, in order to take a short rest before taking up their new work. Sister Job also leaves us on July 27th. We sincerely regret the loss of these valuable workers.

On June 22nd the following appointments were made to fill the vacancies which have occurred—Miss Laurence was transferred from Cornelius to Charity; Miss Lambert was appointed Sister in Cornelius ward (date, July 1st); Miss Loveday was appointed Sister in Astley Cooper ward (date, July 1st); Miss Beardoe-Grundy was appointed Sister in Job ward (date, July 27th).

During the first fortnight in July the following Sisters will start on holiday, and their duties will be taken by—Sister Philip's by Miss Harbottle; Sister Ruth's by Nurse Mullett; Sister Mary's by Nurse Harding; Sister Out-patients' by Nurse Willes.

During the next few months Nurse Tippetts will do Sister's duties in the Surgery.

We have much pleasure in noting the success of another of our old workers. Miss Measures, who has for some time been Assistant Matron at the "Dreadnought" Hospital, has been appointed Sister-Matron of the Gravesend Hospital. Miss Measures gained her three years' certificate in Guy's in 1889.

Chapel News.

The annual general meeting of the members of the congregation took place on June 4th, after the evening service. Dr. Perry presided, and there were thirty-one members present. Some alterations were made in the rules of the Church Council, which will in future be known as the "Guy's Hospital Chapel Committee." The members of the committee for the ensuing year are—Ex-officio; The Bishop of Rochester, the acting and assistant Chaplains, the Superintendent, the Matron, and the Honorary Secretary (Mr. F. Shufflebotham). Elected: Sister Bright, Sister Patience, Miss Isles, Sister Esther, Nurses Finnemore, Haughton, Lambert, Tippetts and Roffey, Dr. Fawcett, Mr. Fagge, Messrs. Fremantle, F. E. Walker, R. C. Mullins and A. R. Thompson.

The following is the balance sheet of the Reredos Fund, which is now closed. The balance over has, with the consent of the donors, been transferred to the Chapel Decoration Fund.

RECEIPTS.	£	s.	d.
To Amount of donations received	160	15	1

EXPENDITURE.	£	s.	d.
By Cheque paid to Messrs. Percy Bacon and Bros.	160	0	0
„ Balance carried to Chapel Decoration Account	0	15	1
	£160	15	1

Audited and found correct,

29th June, 1899. C. H. WELLS.

Nursing Notes.

THE Nurses were very much surprised and pleased to see an invitation to a Concert posted up in the Dining Hall, as they had entirely abandoned the idea that there would be one this year. As it was, it was much more enjoyable to have one when there are so few festivities about than at a time like Christmas, when every one is tired out with their own and other people's concerts. It is safe to say that everyone who could go went, to hear an excellent and well-arranged programme.

Where everyone performed so well it seems invidious——(We cannot allow the rest of this well-worn excuse for lack of criticism to stand. Ed.) The song that apparently appealed to most of the audience, and that excited most comment, was Mr. Miller's "She had to make other arrangements." (Author and composer are unknown). Everyone thought it an exhibition of singular bravery on his part, but it met with so much approval that by special request the song was repeated for the benefit of the day nurses.

Now, about the dresses? There was a wonderful unanimity as to the style, colour, and material, but evidently it is not quite the thing for gowns to fit too well, neither does it seem certain whether buttons or pins shall be worn on apron strings and bands. Sisters' gowns are much admired by nurses, these days.

Not having had an opportunity to thank our hosts we should like to express now to Monsieur the President and Messieurs the Residents, our gratitude for a most delightful evening. We suffered from over-clapped hands to such an extent that we were unable to put on gloves to go to the sports, but we regret none of the applause for it was in a good cause.

The sports came off on the following day. We certainly prefer them to a cricket match; for one thing the feminine mind needs a special instinct to understand that game, as there seems so little relation between the apparently aimless movements of the players and the unintelligible figures on the scoring board, while there is something definite in a race which is over in a few minutes, or a tug of war. We should lament the result of that same tug of war if it did not point to the fact that a continued residence in Guy's leads to an exchange of strength for brains. We couldn't see as much as we wished as the intervals between the events were so long.

Efforts to impart knowledge overheard in the Park. "Yes, first comes the colon, then the semi-colon, then the cakum." Evidently this nurse uses that pronunciation of Latin that speaks of "Cæsar" as "Kaysar."

"L'INCONNUE."

Passim.

FOR the last fortnight the air has been full of appointments of all sizes and dignities from Assistant Physician down to Surgical Ward Clerks. Of these the lesser are of no especial interest, being in the ordinary routine of things, the real excitement being over the applications for the fairly numerous vacancies on the Junior Staff. How these would be filled up and by whom formed subjects of much debate, and the interest has hardly yet died away.

IT is a happy event that this is one of those comparatively rare occasions when the decisions of the Staff are in absolute accord with popular opinion, for this latest list has been greeted with great approbation and with no dissentient voice. The opinion has been practically universally expressed that "if we had been in their place we should have chosen the same men for the same posts." Even the most captious critics are silent for the nonce.

THE most popular part of the list undoubtedly was the appointment to the posts of Surgical and Medical Registrars of Messrs. L. H. McGavin and A. J. Cleveland respectively. Both have been promoted, so to speak, from the rank and file of men still working at the hospital, and will, from the great personal popularity of both, still further serve to strengthen the bond of union between the men and the Junior Teaching Staff.

ON the Surgical side the changes have been especially numerous. Through stress of work Mr. Fripp has had to resign the post of Senior Demonstrator of Anatomy, and Mr. F. J. Steward has taken his place. The other two demonstratorships have been filled by Messrs. C. H. Fagge and R. P. Rowlands; so, if new brooms sweep clean, the dissecting-room ought to flourish in the near future.

WE notice with great regret that Dr. Hale White has resigned the post of Lecturer on Materia Medica. His fascinating style of handling the subject instilled new life into the dry bones of one of the dryest parts of the medical curriculum, and made the course of lecture one of the most attractive given at the hospital. However, the mantle of Elijah has fallen upon Elisha, and nobody at the hospital is more fitted to be his successor than Dr. Perry, whose intimate knowledge of the subject from the point of view of the dispensary and pharmacopœia is unequalled. We shall hope in future never to see Tinct. Ferri Perchlor. prescribed where its cheaper substitute, the Liquor of that ilk, will serve the purpose. There is room for much economy in the ordinary run of hospital prescriptions.

LAST week Mr. F. S. Batchelor sailed for Cairo to take up his new appointment of Resident Surgical Officer at the Government Hospital there. No man of his time will be more missed, as he was one of the most popular men of recent years. A good man at his work, an athlete and a gentleman, he was as fine a type of Guy's man as one could wish to send out anywhere, and we hope he will make as many friends at Cairo as he did at Guy's.

ONCE more the small available space of the Park is being encroached upon. The hoardings have gone up to enclose the space necessary for the commencement of the Henriette Raphael Nursing Home, which will occupy eventually the whole of the space now taken up by the Laundry, and much more besides. Meanwhile, unseen by most of those in the hospital, great progress has been made with the new laundry buildings which are in active progress just behind the present building. The magnitude of these undertakings is a good object lesson of the vast needs of the hospital in the way of necessary improvements.

THE Tug of War scare is still at its height, and the great inter-firm contest came off on Monday and Tuesday evenings last, amid an admiring concourse of spectators, in the Park in front of Clinical. The prize was a handsome silver cup presented by Mr. Clement Lucas, whose own firm eventually proved victorious, and so kept the cup among his own dressers. It would be better if in the future these contests could be decided at Honor Oak Park, as the one available path in the Park at the hospital is hardly an ideal place for many reasons. However, all things must have a beginning, and no doubt improvements will be made in the arrangements in the near future.

WE are also requested to announce that on Monday evening next, at 5.30 p.m., in the Park, Messrs. Mills, Judge, Webb and the gardener will pull Messrs. Prestage, Evans, Chivers and the side-gate porter for a prize of a brace of

pigeons per man in the winning team, to be presented by Mr. Betts at the close of the contest. There will be no gate.

The results of the examinations for the Treasurer's Gold Medals were made public last week. Mr. G. S. Simpson has won the Gold Medal in Medicine, and Mr. C. T. Hilton won the Surgery Medal, and they are both to be congratulated for their well-deserved honours. Mr. R. H. J. Swan is also to be congratulated on winning the Bredin Prize for Clinical Study.

The Nurses' Concert on Tuesday week last was a great success. It is hardly our place in these columns to praise the concert as the men were responsible for the giving of it, but how thoroughly it was appreciated will be seen from the hearty recognition of the efforts of the Residents in "Nursing Notes." We can say, however, on behalf of the Residents, that it was a pleasure to do anything for such a splendid audience.

The Sports were held on our ground last Wednesday week. The clerk of the weather behaved handsomely, and the secretaries of the Athletic Club added their share in making the meeting a great success. Except from the point of view of the man with a watch, there was some fine racing, some really plucky racing, and the men who had trained at all—Sime, Trail, Roper, Nash, F. M. V. Smith and others—showed to advantage. There was a good gathering of the Staff, and we hope this meeting, now regularly established on our ground instead of at Stamford Bridge, will become more and more a cosmopolitan gathering of Guy's society, of both sexes.

But our special correspondent's remarks about the band and the refreshments are worthy of attention. The band ought to be better and the Clubs' Union ought to give their guests refreshments. It is not a hospitable thing to make people pay for what they eat. How it is to be done is another matter. It ought to be done, and that is enough for Passim.

The Junior Inter-Hospital Lawn Tennis Cup, generously promised by Dr. Washbourn, is to be fought for at Honor Oak to-day for the first time. London, George's, St. Thomas's and our own club are sending teams, and we hope the venture will prove a success, considering the success which has attended the inauguration this year of second teams at the hospitals.

The Annual Tennis Match against the Staff was played on Thursday last, and was a great success in every way. Drs. Washbourn and Stevens, Hyslop and Starling, Beddard and Spriggs, Shaw and Bryant upheld the honour of the Staff, but the surgeons were conspicuously absent. Several ladies assisted in encouraging the Staff, and Mrs. Shaw as hostess dispensed refreshments. Our team were plied with unremitting attention before their matches, while the Staff recruited themselves with caution. Nevertheless, the Staff, after several severe encounters, were finally beaten by 6 matches to 4.

The Old Clothes Basket for the Samaritan Fund is now in the College quadrangle, asking for more. Amongst those contributions present we noticed the top hat of a person in high circles, a pair of broken pumps once seen on the feet of a noted surgeon, a set of white cuffs, a toothbrush and many pairs of white kid gloves. Will any other gentlemen kindly help the poor? The basket has had a run of three days, and promises a revival at the end of September.

The Cricket Team have not been doing so well of late. In the Past v. Present match on June 17th, the 1st XI. went in first and made 242. The Past men then had an innings and rapidly knocked up 283 for four wickets. Clarke making 113 and Alexander 119. The rest of the Past team did not bat. And on June 19th, the XI. were knocked out in the second round of the Inter-Hospital Cup by St. Thomas's, mainly owing to the lack of bowling talent in the team. F. C. Wetherell, however, made a good score of 135.

The Annual Inter-Hospital Water Polo Tournament will take place at the Bath's Clubs on Tuesday week next, July 11th.

Notice.

MEDALS AND PRIZES.

The Treasurer's Gold Medal for Clinical Medicine has been awarded to Mr. G. S. Simpson.

The Treasurer's Gold Medal for Clinical Surgery has been awarded to Mr. C. T. Hilton.

The Bredin Prize for Clinical Study has been awarded to Mr. R. H. J. Swan.

Guy's Hospital, June 23rd, 1899.

Acute Infections due to Unsound Meat.

BY HERBERT E. DURHAM, M.A., M.B., F.R.C.S.,
Grocers Research Scholar; Pathological Laboratory of the University of Cambridge.

(Reprinted from the *Clinical Journal*, June 7th, 1899.)

ACCORDING to the old proverb, preventive medicine should be better than therapeutic, when it is successfully carried out. It is necessary, however, to know something about the life of the infective agent during its sojourn outside the human body, before it is possible to take steps in effective preventive hygiene. In cases where the infection can be traced back to certain diseases in particular animals, there is much more promise of successfully combating a given infective disease than is the case where the materies morbi is supposed to be carried about in the air or some such vague method.

It has been recognised for many years that certain forms of severe illness could be traced to the consumption of particular samples of meat. Nearly twenty years ago it was pointed out by Bollinger that these outbreaks were due to the consumption of meat derived from diseased or unsound animals; before, and, indeed, for a good many years after Bollinger, it was commonly supposed that the meat was in a more or less putrid condition, and that substances were formed in it by putrefactive germs which were endowed with poison-producing properties. Poisons were isolated by chemical means, and found to belong to the group of bodies known as alkaloids; hence arose the generic term, "ptomaine poisoning," a term which is still used occasionally even now. During the last ten years our knowledge concerning these outbreaks of illness has been placed upon a more exact footing. This is due to careful bacteriological investigation. Out of the number of observers who have contributed to our knowledge in this manner, I may mention the names of Gärtner, who was the first to isolate and describe a new and characteristic bacillus as the cause of the illness, and of Professor van Ermengem, who has dealt with more epidemics than any other author, and who has not only described the nature of another specific organism, but who confirmed the presence of Gärtner's bacillus in a number of outbreaks. At the present time these two microbes, that of Gärtner or Bacillus enteritidis, and that of van Ermengem or Bacillus botulinus, takes the foremost place in the list of causative agents of meat-poisoning. Besides these bacilli, several others have been described as having given rise to illness, and many of these are of the nature of putrefactive bacilli—proteus, etc.—and are not certainly to be identified with the causation of the illness, for the materials were often investigated at a late stage, when putrefactive changes had already set in. In a piece of liver from a person dead of enteritidis infection, at first the B. enteritidis far outnumbered all other organisms; when I re-examined the material at a later date only proteus bacilli could be discovered. Here it is to be observed that meat that is dangerous is by no means putrid, indeed, it may be quite good in appearance and in smell. It is commonly believed that these infections occur only in hot weather; however, reference to the literature of the subject shows that outbreaks may occur at any time of the year. For instance, one of the epidemics which I investigated occurred in January, whilst others have taken place in the autumn and spring. However, the warm season is not without importance, for it encourages the growth of bacilli, and a joint of meat, which contains only a few bacilli, may become dangerous when it has been kept for a period which would not have made it so in colder weather. A crucial test of this is to be found in the *experimentum in homine*, which was made by Poels and Dhont, in Holland, with the flesh of an artificially inoculated ox.

INFECTIONS BY THE BACILLUS ENTERITIDIS.

In meat poisoning, the bacillus enteritidis of Gärtner is by far the most important organism, for already a large number of outbreaks have been found to be due to it, and from the records of many of the earlier outbreaks, extending over several thousand cases of illness, with a death rate varying between 1 in 200 and 1 in 5, were very probably due to the same cause.*

Clinically, two types of fever may be distinguished, the one cholera-like, and the other typhoid-like. Vomiting and diarrhœa are usually the two most prominent objective symptoms; very characteristic also is the extreme collapse, and the slow restoration to health and strength when recovery occurs. Lung affections (pneumonia), exanthemata, and other symptoms have been special features in certain epidemics. Relapses are common, so that the acute stage of the illness, instead of lasting only five or six days, may go on for as many weeks. In respect to the similarity to enteric fever, it is interesting to observe that the lesions noted at autopsies have not infrequently been described as those of an "early stage of enteric fever" (swollen Peyerian patches, etc.); a certain amount of suspicion may be entertained about some of the recorded cases of "enteric fever without intestinal ulceration," for the Bacillus enteritidis closely resembles that of enteric fever in many respects. It can, however, be readily distinguished by its power of fermenting grape-sugar at the body-temperature, as well as by means of a number of other tests.

Attention may now be drawn to the evidence that the illness is due to an actual infection with living bacilli, and not simply to the formed bacterial products, and also that it is communicated by the flesh of diseased animals. Ballard came to the conclusion that the illness was of an infective nature, but he did not trace out connections with disease of the meat-supplying animals, as Bollinger had previously done. Since Gärtner made the discovery of the Bacillus enteritidis in the flesh of a diseased cow, and in the organs of one of the persons who died in consequence of eating the flesh in a more or less uncooked

* A series of short reviews of forty-two outbreaks will be found in Kobert's 'Lehrbuch der Intoxicationen,' p. 710, Stuttgart, 1893.

condition, similar results have been obtained in a considerable number of instances. In a further number of outbreaks the same bacillus has been found in the organs of fatal cases, whenever search has been made for it sufficiently soon after death. The demonstration of one and the same specific organism in the diseased meat, and in the organs of those who died from consuming it, forms a satisfactory proof of the notion of "intestinal sepsis," enunciated by Bollinger in 1881.

In connection with many of the epidemics, it has been shown that persons who partook of meat in a properly cooked condition were unaffected, whilst those who consumed uncooked or partially cooked meat became more or less severely affected. In this country the consumption of meat in the raw condition is not so common as is the case in some other countries, where uncooked sausages are very largely eaten. Until last year this bacillus had not been described in England, nevertheless, outbreaks of this infection do occur in this country; indeed, I have myself isolated the bacillus from the organs of a fatal case in an epidemic affecting nearly two hundred people; and, moreover, by means of the methods of serum-diagnosis, I have shown that three other epidemics were due to the same cause. All these four outbreaks occurred between January and August of last year. The origin of most outbreaks has been traced to beef and to veal obtained from sick animals suffering from puerperal fever, metritis, septicæmia, pyæmia, or diarrhœa, respectively.

It appears that infective conditions are rather common in cows, as a result of uncleanly treatment when calving. It appears that the milk may be the means of communicating the disease; happily, however, milk secretion is arrested for a while. Calves are apt to become ill with some septicæmic disorders, of which many die; the same is said of young pigs. The actual nature of these infections has not yet been satisfactorily worked out; it is, perhaps, significant that Thomassen has isolated a bacillus from sick calves, which apparently belongs to the enteritidis group of organisms. Schneidemuhl thinks that some of these disorders are due to the Bacillus botulinus, which is dealt with later.

Although the flesh of other animals (pig, horse, and goat) has been found at fault, as yet we do not know very much about the distribution of the bacillus in nature. It is significant, perhaps, that the Bacillus enteritidis of Gärtner is extremely like a number of other bacilli, which may, in fact, be considered as varieties which should be included in one group; some confusion has arisen, in that some of the bacilli have been placed amongst the bacteria of "hæmorrhagic septicæmia," whilst others have been grouped amongst the Bacillus coli-like organisms. Of these, the hog-cholera bacillus of Salmon and Smith, and the Bacillus typhi murium of Lœffler may be particularly noticed (Theodore Smith insisted on their similarity to Gärtner's bacillus many years ago). In a recent paper by Voges, the author finds cause for congratulation, in that hog-cholera has not, as yet, been introduced into Germany, yet the Bacillus typhi murium may be described as a marketable article, cultures of which can be obtained to distribute upon bread, etc., for the purpose of destroying plagues of mice. Under any circumstances, such a use of living microbes can only be considered as a form of playing with edged tools, but here the moral seems more pointed. It is to be hoped that the seeds of disaster have not already been sown. It is also interesting to note that one of the outbreaks in Germany (in which B. enteritidis was found) was traced to a pig.

There are many points of interest and importance which still remain to be cleared up. For instance, we do not know what degree of immunity is conferred in man by a single attack. It is, however, not probable that so effective an immuniny is acquired in this disease as is the case in enteric fever, for in any subsequent exposure to infection, a considerable dose of highly virulent material may be consumed; acquired immunity is only of relative value, for we do not know any instance where it does not break down when a sufficient dose of sufficiently virulent material is introduced. In the case of enteric fever, probably only a few of the specific bacilli are taken at any given time of infection, so that by means of a slight degree of acquired immunity, we are able to deal successfully with them; as has already been stated, the contrary is probably often the rule in the case of enteritidis infections. The Haffkine plague prophylactic injections may be cited as an illustration, although they are usually effective in fending off the disease as it is acquired naturally, yet to judge by the recorded cases of accidental and fatal infection by cuts at *post-mortem* inspection of plague corpses, it is not effective in the face of such direct infections. Generally speaking, the debates which have been raised as to whether it is possible for second attacks of syphilis to occur, are absurd from the bacteriological point of view, according to which such attacks are always possible, given that a sufficient amount of a sufficiently virulent material is introduced.

In regard to enteritidis immunity, there is a further problem of interest, for we know from experimental work that a certain degree of mutual immunity is demonstrable between this bacillus and the typhoid bacillus. We know that in any typhoid epidemic a number of persons escape the infection; it is not impossible that in some cases an enteritidis immunity may play a part, for these infections are probably far more common than has been established at present.

At present further knowledge is wanted of sporadic cases of these infections in man. From the occasional resemblance to enteric fever, it is not impossible that cases which are regarded as enteric fever, may sometimes be of the nature of infections with the Bacillus enteritidis. Owing to the method initiated by Gruber, we have a means of determining which of the two diseases is present, for, by testing the blood serum in a series of dilutions upon the two forms of bacilli, we can differentiate between them. Unfortunately a French observer introduced a routine for the performance of the test in low dilutions, which are not even beyond the

limits of action of some normal serums, and this has been too rigorously adhered to. This is the more regrettable in that the serum of enteric fever patients, or convalescents, has clumping effect upon the B. enteritidis, and conversely the serum of persons who have been ill with infection by B. enteritidis has effect upon the typhoid bacillus, unless certain dilutions are exceeded. I have advocated the routine employment of a graduated series of serum dilutions, which are then tested upon a considerable variety of different races of bacilli, in this wise it is possible to make a differential diagnosis between the two diseases. Recently my observations have been completely confirmed by Dr. de Nobele (working in the laboratory of Professor van Ermengem); from his examination of the serum of persons who have suffered from the enteritidis infection, he comes to the conclusion that in order to establish a diagnosis of enteric fever, reaction must be obtainable in dilutions above 1 in 50. In the serum obtained from the epidemic of enteric fever at Lynn, I found that in two cases the reactions pointed to the infection being due to the Bacillus enteritidis; also, in the Belfast typhoid epidemic, Lorrain Smith came across a case from which this bacillus was isolated. With more care in the way in which the serum test is performed, we may confidently await further light upon the differentiation of these diseases and their relative prevalence in sporadic form. The nature of the illness which is occasionally caused by the consumption of shell-fish is, at present, more or less mysterious, and I should be extremely obliged to any of my readers for timely information or for material from outbreaks of this nature. (For notes on obtaining material at *post-mortem* examinations, etc., see my paper "On the Present Knowledge of Outbreaks due to Meat-Poisoning," *British Medical Journal*, December 17th, 1898.)

Illness Caused by the Bacillus Botulinus.

The only account we have as yet of an outbreak, which has been proved to have been caused by this organism, is due to its discoverer, Professor van Ermengem. The symptoms of the illness, however, are so characteristic that this author has been able to collect a number of accounts of other outbreaks, which were probably due to the same or some similar microbe. This disease or botulism is quite different in its nature from the disease which we have just been discussing. The Bacillus enteritidis acts largely by its great power of causing a general infection, whilst the Bacillus botulinus belongs apparently more to the toxic type of disease germs, like that of tetanus. The outbreak in which the B. botulinus was discovered occurred amongst the members of a musical society, who supped together; the incriminated victual was a ham. The remains of the ham, and the organs of one person who succumbed, were submitted to bacteriological research; from both of these sources a new bacillus was isolated. This bacillus is only able to grow in the complete absence of free oxygen; it is able to form spores, which, however, are less resistant to heat than the spores formed by many other bacteria. The most important point is its faculty of producing a most intensely poisonous body, which is readily destroyed by heat, and is similar in its nature to the toxins formed by the diphtheria and tetanus bacilli; the power of the poison may be judged of by the fact that 0·0001 c.c. is a certain fatal dose by subcutaneous injection in rabbits. From the fact that the bacillus is to be found in the organs (spleen, etc.) of the person who was fatally affected, as also of experimentally-fed animals, it is clear that here we have not to deal with a simple intoxication with the poisonous products. The effects produced in the disease point especially to affection of the nervous system; in consequence of this, Professor van Ermengem had attention paid to the central nervous system in the experimental animals. It was found that there was an extensive "chromatolysis," or destruction of Nissl's granules in the nerve-cells, and it is pointed out that in future outbreaks heed should be paid to the histological changes in the central nervous system.

I quote the following summary of the clinical symptoms from van Ermengem:—

1. Arrest or hypersecretion of the salivary or buccopharyngeal glands. (The collection of thick mucus in the nasopharynx was a characteristic and very distressing symptom.)

2. Ophthalmoplegia externa; ptosis, mydriasis, paralysis of accommodation, diplopia, and internal strabismus.

3. Dysphagia, aphonia, intractable constipation, and retention of urine. (Vomiting was very troublesome, in a few cases there was some diarrhœa.)

4. General weakness of the voluntary muscular system.

5. Absence of fever, and of disturbances of sensation and intelligence.

6. Disturbances of the circulatory and respiratory systems are of frequent occurrence, and may lead to death by bulbar paralysis.

7. Incubation period is not less than twelve to twenty-four hours. Gastro-intestinal trouble may last for several weeks.

It is to be noted that not only does proper cooking destroy the bacillus, but that a proper amount of salt in the pickling brine (10 per cent.) will certainly prevent the growth of the bacillus, for a strength of 6 per cent. is sufficient to do so.

I should add that Kempner and Pollack have prepared an efficient antitoxin for the botulinic poison; perhaps, some day this will be used in the service of man.

It should be always kept in mind that the only way to establish our knowledge of diseases of this nature is to take prompt action, in order that bacteriological investigations may be undertaken before the true nature of the condition has become masked by the onset of putrefactive alterations. With the mutual assistance of the practitioner, the sanitary authority, the veterinarian, and the bacteriologist, we may look forward with confidence that our present ignorance of the nature of mysterious outbreaks will be successfully mended in the future.

In Lighter Vein.

"WHEN THE PAKER SLEEPS."

HAD I the pen of G. P. R. James (as Thackeray once observed), I should describe how on a balmy summer evening two travellers might have been seen emerging from a wood, only the trees had mostly been felled, and those which remained had been transplanted with a mortality of 99·8 per cent. As to the two travellers, one of them was certainly *bona fide*, while the other's auburn locks and aseptic hat betokened a scientist of some reputation. The former, who might have seen some fifty summers, tho' a well-preserved man for his age, bore unmistakeable traces of the hand of time.

"There have been many changes here," said the scientist, glaring at a fourteen-storied edifice built entirely of glazed tiles, "since I was first admitted into what we used to call 'Clinical'—but that was before your time."

"Yes," replied the other. "When I was first appointed House-Surgeon ten years ago, I remember seeing you moved in a state of unconsciousness into our Museum for Patients of Pathological Interest, but even I have seen many changes since I entered here thirty years ago."

"I was admitted," replied the scientist, in a dreamy voice, "for cigarette smoker's tongue in the autumn of 1900. They gave me an overdose of anti-pneumococcin, a drug then in vogue, because the Clinical thought he heard a rub at my right base. I wish," he continued, adjusting his tie, which had slipped up behind, "that I had never awakened from the fifty years' trance which followed. If I had only had pneumonia—but that is supposing the Clinical's diagnosis had been correct. But you have been here a long time: how is it that you are still a House-Surgeon?"

"The year I joined," replied the other, "the new twenty years' curriculum was introduced, which includes five years at an asylum and five years at special hospitals. And then for five years I was doing extension dresser to the entire Staff—a system introduced to prevent any unfairness to the senior surgeons."

"Yes," said the scientist, "the first move was made in that direction when I was Assistant Demonstrator; but that reminds me, where is the Bacteriological Department? The sight of *agar agar* might make me young again."

"Oh, that old place," exclaimed the House-Surgeon. "That's been turned into a Temporary Accommodation for Ward Maids years ago."

"But where is your present Bug—I mean Bacteriological Laboratory?"

"We haven't got one now. You see, there are no bacterial diseases since the Sterilization of London Act."

"No bacteria, no sepsis, no pyæmia!" gasped the other. "But operations, do they never go wrong?"

"No!" replied the House-Surgeon, proudly. "We are now necessarily aseptic, and any operation which fails is due to some error on the part of the surgeon. Why, we never cut our nails, and the usual dressing is linoleum. Medicine has advanced equally; one of our physicians made two diagnoses this month which were verified at the *ante mortem*."

"How many full physicians have you on the Staff now?" enquired the scientist.

"I don't quite remember," replied the H.-S. "You see they only write reports and take temperatures; the Assistant Staff run Out-Patients, and the wards are managed by the Residents."

Just then an elderly man with a portly frame strolled by.

"Allow me to introduce you," said the House-Surgeon, "to one of my very best dressers, Mr. Gamavin. His father, who came of an old Welsh family, did Surgical Registrar at the end of the last century. He gained his appointment owing to distinguishing himself two years ago in the Tug of War against the Nursing Staff."

"I hope you're all right now," said the dresser, cheerfully. "Have you seen our new Challenge Cup? It was presented by the General Medical Council to the Inter-hospital Team who could take the longest time killing a cat."

"I am glad," responded the scientist, "to see that the old sporting spirit is not yet dead at Guy's. But tell me about the tug of war."

"The idea of the Tug of War," said the House-Surgeon, "was first suggested some years ago at a boating party for nurses and students given by the ward clerks and junior pros. Being dresser at the time, I was asked."

"But was this allowed?" asked the scientist, with a touch of sadness in his voice. "You have advanced since my time."

"Oh," replied the dresser, "the nurses' minimum age limit for entrance is forty-two, and they don't get their fringes as staff nurse till fifty. So the relations between nurses and the medical staff are much altered for the better. Why, now-a-days no resident is allowed to sit down while the nurses are in the ward."

"What is that bell ringing for?" enquired the scientist, abruptly. "Is it for some lecture?"

"We have no lectures now," said the dresser. "The students criticise the treatment of the Medical and Surgical Staff every morning before breakfast. But it's not of much use, as the Staff *will* read the morning papers, and often go out before the end."

"Before breakfast!" said the scientist, turning pale. "But, surely, the Residents aren't there then?"

"Why, yes," said the House-Surgeon. "They always rise at 7.30——"

But the scientist had swooned.

C. H. G. HOWLS.

Concert in the Court Room.

IN past years the Nurses' Concert has always been given in Christmas week, an arrangement which was convenient but had disadvantages. For, just consider what happened. First of all the niggers went round on Christmas-day; then they appeared in the court room, bringing the same songs; then came the ward concerts with a large muster of hospital musicians, performing yet again the same songs, by this time bald and toothless.

All of which means that we consider the holding of the Nurses' concert in the summer a good idea, and one to be repeated. A long and attractive programme was got through with evident success to a thoroughly appreciative audience, and the President of the Residents is to be warmly congratulated on the admirable results of his efforts. Mr. Colegrave opened the programme with a tasteful rendering of Liszt's "Valse Impromptu," after which Mr. Parrott sang in good voice.

Miss Bateman (Mrs. Crowe) recited the Quarrel scene from the "School for Scandal," with fine art, while the results of her tuition were seen to advantage in recitations by two of her pupils, Miss Victoria Wright and Miss Irène Beusz.

Sister Christine sang with rare feeling and distinction a little French song, Miss Blount played the violin with taste and good technique, while songs were contributed by Mrs. Parry, Mr. Atkins, and Miss Shuldham.

Our only Arthor was in immense form with what is rumoured to be a little thing of his own: he said he had a headache; I have noticed before that headaches agree with him. The first part of the programme was concluded by a really fine performance of Chopin's A flat Ballade, by Miss Eason.

Part II. commenced with the first movement of Rheinberger's Quartet in E flat, a thoroughly good performance, in which the Eason family loomed large under the leadership of Mr. Raaschou as first fiddle.

Mrs. Parry sang two Irish songs delightfully, Miss Blount played another violin solo, and showed to even better advantage than in the first part. Miss Shuldham sang again, displaying a fine voice and excellent style, while Mr. Miller eclipsed all previous records.

Mr. Raaschou gave a beautiful rendering of Svendsen's "Romance" for the violin; Sister Christine again delighted us, this time with a song from Faust, while a special note must be made of Miss Haweis' nigger songs, which were quite the event of the evening. More songs by Messrs. Parrott, Cazenove, and Fitz-Hugh, two duets of Mendelssohn by Mrs. Parry and Sister Christine, and then "God save the Queen," played by Mr. Fremantle with daring originality. Altogether a thoroughly enjoyable evening. May we be there to see many more such.

Appointments.

The following appointments have been made by the Treasurer upon the recommendation of a Staff Meeting:—

Dr. PERRY to be Lecturer on Materia Medica.

Mr. FRIPP to be Demonstrator of Surgical Pathology.

Mr. L. H. MCGAVIN to be Surgical Registrar and Tutor.

Mr. A. J. CLEVELAND to be Medical Registrar and Tutor.

Mr. F. J. STEWARD to be Senior Demonstrator of Anatomy.

Mr. C. H. FAGGE to be Demonstrator of Anatomy with charge of Dental Classes.

Mr. R. P. Rowlands to be Demonstrator of Anatomy and Biology.

The following reappointments have been made:—

Dr. T. G. STEVENS, Demonstrator of Biology.

Mr. W. C. C. PAKES, Demonstrator of Sanitary Science and Bacteriology.

Mr. L. PANTING, Demonstrator of Chemistry and Physics.

Dr. A. P. BEDDARD, Demonstrator of Physiology.

Dr. T. B. HYSLOP, Demonstrator of Psychology.

Mr. G. BELLINGHAM-SMITH, Demonstrator of Morbid Histology.

Messrs. GOADBY, PARFITT, PARE, PAYNE, WOOD, Demonstrators of Practical Dentistry with Revision Classes.

Mr. WOOD, Demonstrator of Practical Dentistry with Extraction Classes.

Mr. PAYNE, Curator of the Dental Museum.

HOUSE APPOINTMENTS.

The following appointments have been made by the House Committee upon the recommendation of the Medical Committee:—

House-Physicians.—Messrs. K. B. Alexander (Dr. Pitt); E. W. S. Rowland (Dr. Taylor).

Assistant House-Physicians.—Messrs. L. E. C. Handson, W. H. M. Telling.

House-Surgeons.—Messrs. R. H. J. Swan (Mr. Golding-Bird); F. E. Walker (Mr. Lucas).

Assistant House-Surgeons.—Messrs. W. L. Baker, F. D. Turner (Front Surgery); A. H. Carter (Mr. Jacobson); D. J. Munro (Mr. Symonds); F. W. Brook (Mr. Lane); G. N. Meachen (Mr. Dunn).

Obstetric Residents.—Messrs. T. P. Berry (from July 1st); W. J. Lindsay (from August 16th).

MEDICAL SCHOOL APPOINTMENTS.

The following appointments have been made by the Treasurer upon the recommendation of the Medical Council:—

Clinical Assistants.—Messrs. A. A. Miller, A. H. M. Saward, A. E. Clarke, G. S. Simpson, F. O. Stoehr. D. P. Watson.

Clinical Assistant in the Aural Department.—Mr. C. H. Fagge.

Clinical Assistants in the Medical Wards.—Messrs. G. M. Brown (Dr. Pye-Smith); W. G. Stewart (Dr. Taylor); A. H. Davies (Dr. Hale White); F. Shufflebotham (Dr. Pitt).

Clinical Assistants in the Medical Out-Patients.—Messrs. J. T. Wright (Dr. Shaw); E. J. Tongue (Dr. Washbourn); E. A. Miller (Dr. Bryant).

Dressers in the Eye Wards.—Messrs. P. C. P. Ingram, R. M. Barron (August 1st) (Mr. Higgens); L. Hirsch (August 1st) (Mr. Brailey); H. A. Higgens (September 16th) (Mr. Higgens); E T. Jensen (September 16th) (Mr. Brailey).

Clerks in the Eye Wards.—Messrs. J. B. C. Brockwell, L. Hirsch, W. W. Harrison, C. H. Glenn (July 1st); M. W. Cohen, M. Coplans, A. H. E. Wall, H. Braund (August 16th).

Dressers in the Throat Department.—Messrs. R. B. Stamford, A. D. Lewis, E. A. Longhurst, A. R. McLachlan, E. Cohen, J. G. Taylor.

Clerks in the Throat Department.—Messrs. C. B. Thomson, F. D. Welch.

Obstetric Dressers.—Messrs. A. W. Penrose, E. W. Goble, E. Cohen, A. R. Thomas (July 1st); C. H. Brangwin, H. Braund, J. M. Brydone, R. Tilbury (August 16th).

Surgeons' Dressers.—Messrs. E. G. Andrew, A. Moon, P. S. Mandy, L. Pern, H. G. Rashleigh, T. B. Fawley (Mr. Howse); W. H. Loosely, B. Muir, E. F. Reeve, R. S. Roper, G. T. Willan, J. A. Wood (Mr. Davies-Colley); F. G. Cross, D. G. Greenfield, A. C. Ransford, J. A. Butler, P. W. L. Camps, F. G. Gibson (Mr. Lucas); T. R. Beale-Browne, H. McD. Parrott, E. J. F. Hardenberg, D. Forsyth, A. Pearson, J. F. Robinson (Mr. Golding-Bird).

Assistant Surgeons' Dressers.—Messrs. J. D. Bridger, H. Davies-Colley, P. T. Manson, N. F. Ticehurst, H. Bentley, D. L. Morgan (Mr. Jacobson); G. S. Graham-Smith, K. V. Trubshaw, E. G. Wales, R. Jiménez, R. P. Marshall, D. W. Smith (Mr. Symonds); S. L. Prall, H. K. Lacey, T. A. Matthews, K. W. Goadby, P. J. Nash, F. M. M. Ommanney (Mr. Lane); M. D. Wood, S. Hodgson, F. W. Smith, H. Wacher, F. W. Sime, F. E. Welchman (Mr. Dunn).

Medical Ward Clerks.—Messrs. H. A. Ehrlich, J. A. B. Hammond, S. J. Ormond, L. E. Stamm, C. B. Penny, W. O. Roberts, E. C. Bevers, G. Clarke, E. I. Claxton, G. G. Davidson, T. H. B. Dobson, H. S. French, C. R. Howard, E. F. Heap, F. B. Manser, R. D. Smedley, R. Thompson, A. Croneen, F. A. Beattie, G. T. Collins, F. Curtis, G. Evans, C. E. Gaitskell, F. D. S. Jackson, H. C. Keates, M. J. Rees, D. H. Trail, S. C. H. Bent, J. F. Douse, J. Evans, A. W. Gater, G. S. C. Hayes, E. Roberts, W. M. Robson, A. W. Soper, A. C. Nash.

Surgical Ward Clerks.—Messrs. E. J. Crew. H. W. Brown, H. J. Gater, G. H. H. Manfield, F. C. Wetherell, W. H. Bowen, M. A. Collins, A. C. H. Gray, C. Tessier, L. J. Hughes, H. A. Cutler, E. Faulks, R. C. Lawry, H. T. Palmer, T. M. Smith, J. A. Andrews, S. Child, E. G. Allport, O. W. Richards, H. P. Wiltshire.

Assistant Physicians' Clerks.—Messrs. T. H. F. Roberts, E. H. Kitchin (Dr. Shaw); D. R. T. Griffiths, E. C. Bevers, E. I. Claxton (Dr. Washbourn); V. M. Wallis, H. S. French (Dr. Bryant).

Clerk in the Skin Department.—Mr. F. D. Welsh.

Post-mortem Clerk.—Mr. W. M. Thomas (August-September).

Aural Surgeon's Dressers.—Messrs. H. B. Dismorr, H. A. Gaitskell, J. Harris (July-August); F. E. Fremantle (September-October).

Dental Surgeons' Dressers.—Messrs. T. E. Holman (July-August); E. E. Parrett (August-September); O. Marriott (September-October).

Pathological Assistants to Surgical Registrar.—Messrs. F. G. Cross, J. F. Northcott.

DENTAL APPOINTMENTS.

The following appointments have been made by the Treasurer upon the recommendation of the Dental Council:—

Dental House-Surgeons (for six months from July 1st). Messrs. S. H. Olver, P. H. H. Palmer, A. E. Rowlett.

Assistant Dental House-Surgeons (for three months from July 1st).—Messrs. F. W. Garman, R. B. Recordon.

Demonstrators in the Conservation Room (for six months from July 1st).—Messrs. S. L. Pallant, J. H. Greenwood, W. R. Searle.

Pass List.

Royal College of Surgeons of England.

FINAL EXAMINATION FOR THE FELLOWSHIP.

F. W. Robinson. S. Copley.

FIRST EXAMINATION FOR THE FELLOWSHIP.

W. H. Bowen, F. Curtis, M. A. Collins, A. C. H. Gray, O. W. Richards, C. Tessier.

University of Cambridge, June, 1899.

DEGREE OF DOCTOR OF MEDICINE.

A. P. Beddard.

SECOND EXAMINATION FOR THE MEDICAL AND SURGICAL DEGREES.

PART II.—ANATOMY AND PHYSIOLOGY.—S. Child, H. A. Cutler, H. P. Wiltshire.

Sport.

Guy's Hospital Athletic Club.

The sports were held, as is now usual, on the Honor Oak Ground, on Wednesday, June 21st, and afforded a most enjoyable afternoon's entertainment. The weather was perfect, not too hot for the athletes nor too cold for the spectators. There was a slight breeze blowing down from the terrace, which was felt in the lap-races, but refreshed everybody. The track, under Harris' direction, was in an almost perfect state, and altogether the conditions were better than have been seen for several years. Amongst those present were Mr. Lucas, President of the Club, and Mrs. Lucas; Dr. and Mrs. Pye-Smith, Dr. and Mrs. Taylor, Dr. and Mrs. Hale White, Mrs. and Miss Galabin, the Misses Davies-Colley, Mr. Higgens, Dr. and Mrs. Shaw, Dr. Bryant, Dr. H. A. Munro, and several Sisters past and present, with other members of the nursing-staff, and a large gathering of our men and their friends. The Committee and other officials did their work well, and the Secretaries are to be congratulated on the result of their indefatigable labours.

The Englishman must have a grumble, and the grumble in this case refers to the band and the refreshments. In neither case does it reflect on the Committee, for it is a question of £ s. d., a question, that is, of the Clubs' Union management. With the present allowance to the Athletic Club, it is impossible to provide a good band, and it is necessary to make people pay for the tea; but, inasmuch as the sports practically constitute the one and only entertainment given by the men to their friends during the year, the ideal would be to make it a more genuine garden-party, to have a decent band, and to provide light refreshments, however simple, free of charge. Whether this ideal can ever be attained it is not for the GAZETTE reporter to say.

An excellent innovation was made in the substitution of a tug-of-war for the long-established three-legged race. Tugs-of-war, we should say; and there were rather too many of them; but seeing the immense popularity of this form of sport in the Park at the present time, culminating in the Surgical Firms' Cup, and seeing the excellent nature of the sport from the point of view of competitors and onlookers, the innovation is much to be commended. In the end the fourth year's team won a most gallant and heroic victory.

The rest of the sport was not of the best. Men are horribly slack now in entering, the counter-attractions of the summer-time being greater than ever, and it is a question whether the sports would not be more successful if held before the cricket and tennis is in full swing. Such excellent athletes as, for instance, the present Secretary of the Cricket Club, would then be available, whereas he and several others made no appearance this year. With a few notable exceptions, men do but little training for our sports as it is; and the team chosen for the United Hospitals' Sports in July would train just as well in any case.

F. M. V. Smith has always trained well since he has been up here, his hurdle-racing is much improved, and his four prizes were well earned. Sime, our best athlete up now, was unfortunate in missing his heat of the 100 yards. Nash has trained well, and is developing into a promising miler, with a pretty style, but was unable to get through from scratch with no one to pace him. German, who won this event and the half, is a distinct acquisition, and may do well in a year or two's time, if he trains assiduously. Pern ran pluckily in both the half and the quarter, which he won, but we have never yet seen him run except untrained. Trail ran a splendid race as usual in the half, but was unable to pull through from scratch. Langdale showed promise, and Roper ran a very plucky race in the 3 miles, coming in at the end with a fine sprint, although in only moderate time.

The bicyclists, despite their astonishing costumes, are really some of the finest performers up here, and May and Gabriel especially distinguished themselves.

The field events were not productive of any very good performances, the best being Trail's put of 31ft. 9½in.

In the Veteran's Race, this year 150 yards only—a much more suitable distance—F. E. Walker won a popular victory, and we were glad to see Barron give him a plucky race.

At the end Mrs. Pye-Smith gave away the prizes, and with two happy little speeches from Mr. Lucas and Dr. Pye-Smith, the sports terminated with the usual cheers.

---

100 YARDS.—Heat 1—J. W. Featherstone, 7 yards, 1; B. N. Stewart, 7 yards, 2; F. W. Sime, 0. Won by one yard. Time, 10⅖sec. Heat 2—F. M. Smith, 7 yards, 1; T. R. Beale-Browne, 10 yards, 2; R. S. Roper, 8 yards, 0. Won by yard and a half. Time, 10⅕sec. Heat 3—A. H. Clogg, 8 yards, 1; D. W. Smith, 7 yards, 2. Won easily. Time, 10⅘sec. Final heat—Beale-Brown, 1; F. M. Smith, 2; J. W. Featherstone, 0; A. H. Clogg, 0. Won by two feet. Time, 10⅖sec.

THROWING THE HAMMER.—M. D. Wood, 79ft. 6in., 1; H. D. Trail, 0; F. W. Sime, 0.

HALF MILE.—H. B. German, 25 yards, 1; L. Pern, 18 yards, 2; D. N. Trail, scratch, 0; P. W. Camp, 25 yards, 0; H. W. Langdale, 35 yards, 0; V. S. Sams, 25 yards, 0. Won easily by 10 yards. Time, 2 m. 3⅖ sec.

BICYCLE RACE.—2 Miles.—R. May, scratch, 1; Gabriel, 2; H. N. Hillier 0.

120 YARDS HURDLE.—Heat 1—F. M. Smith, owes 10 yards; Dignum, w.o. Heat 2—J. W. Featherstone, scratch, 1; E. G. Wales, scratch, 2; V. S. Sams, scratch, 0. Final Heat—Smith, 1; Featherstone, 2. Won by 7 yards. Time, 19⅘ sec.

ONE MILE.—H. B. German, 70 yds., 1; W. Jarvis, 70 yds., 2; L. G. Nash, scratch, 0; R. S. Roper, 45 yds., 0; M. D. Wood, 110 yds., 0. Won by 30 yds. Time, 4min. 47sec.

PUTTING THE SHOT.—H. D. Trail, 31ft. 9in., 1; R. C. Mullins, 2; French, 0.

INTER-TEAM, TUG OF WAR.—First Round, Fifth year scratched; First year beat Crocks'; Third year beat second year. The fourth year pulled a scratch team second round. Fourth year beat first year. The third year pulled a scratch team. Final Round.—Fourth year beat third year.

220 YARDS.—J. W. Featherstone, 17 yds., 1; H. W. Langdale, 17 yds., 2; D. W. Smith, 14 yds., 0: R. G. Anderson, 17 yds., 0; J. H. Webb, 17 yds., 0; H. D. Trail, 17 yds., 0. Time, 2min. 4⅘sec.

VETERANS' RACE, 150 yards.—F. E. Walker, 6 yards, 1; A. E. Longhurst, scratch, 0; H. A. Higgens, 8 yards, 0: R. M. Barron, 15 yards, 0. A good race; the scratch man after having all but caught his man, failed to stay the distance.

BICYCLE RACE, 5 miles.—R. C. May, scratch, 1; Gabriel, scratch, 2; W. E. Lowe, 150 yards, 0.

HIGH JUMP.—F. M. Smith, owes 1 inch, 5 feet ¼ inch, 1; Dyson, scratch, 0; Searle, scratch, 0.

440 YARDS.—L. Pern, 12 yards, 1; J. W. Featherstone, 17 yards, 2; D. W. Smith, 18 yards, 0; F. M. Smith, 19 yards, 0 Time, 55⅕secs.

LONG JUMP.—F. M. Smith, scratch, 18 feet 6 inches, 1; J. W. Featherstone, scratch, 2; E. G. Wales, scratch, 0.

THREE MILES.—R. S. Roper, 20sec., 1; W. Jarvis, 1min. 20sec., 2; R. E. Brayne, 35sec., 3; F. E. Fremantle, scratch, 0; F. M. Ommanney, 1min. 30secs., 0; A. C. Osborne, 2min., 0. A good race, all three men being well up at finish.

D. H. TRAIL,
F. W. SIME,
Hon. Secs.

Cricket

PAST v. PRESENT.

Played at Honor Oak Park on Saturday, June 17th. F. J. Nicholls had got a strong team to represent the Past. The Present won the toss and started to bat on a good wicket, but did very badly against the bowling of A. E. Clarke and W. I. Hancock, the first 5 wickets falling for 42 runs. Willan and Bowle then made a stand, and put on 74 runs for the next wicket, the former being caught just before lunch for 38. Afterwards Bowle soon passed his 50, and Grellet made some fine hits. Bowle was out for 67. With Strange as a partner Grellet scored fast, and at the close of the innings had made 64 not out; considering the poor start, our total of 242 was not so bad. There were two hours and a half to play when the Past began to bat, and after Francis was bowled, Clarke and Alexander quite collared our bowling, and each made a century, the runs were knocked off with twelve minutes to spare, and at close of time their score was 283 for 4 wickets. Scores:—

PRESENT.

F. C. Wetherell, b A. E. Clarke	4
K. V. Trubshaw, b A. E. Clarke	16
R. C. Poyser, b Hancock	2
J. M. Brydone, lbw, b Hancock	18
H. M. Langdale, c Humphrey, b Clarke	0
S. C. Bowle, b Alexander	67
G. T. Willan, c Yorath, b Clarke	38
H. R. Grellet, not out	64
C. M. L. Cowper, b A. E. Clarke	0
E. W. Strange, c Durbridge, b Alexander	15
H. P. Wiltshire, b Alexander	0
Extras	18
Total	242

PAST.

A. E. Clarke, c Brydone, b Trubshaw	113
C. J. Francis, b Strange	11
K. B. Alexander, c Willan, b Wiltshire	119
W. I. Hancock, b Wiltshire	12
F. J. Nicholls, not out	5
Extras	23
Total (4 wickets)	283

L. Humphrey, C. J. Yorath, H. Durbridge, J. H. Busteed, C. H. Fagge, F. E. Walker did not bat.

GUY'S v. ST. THOMAS'S.—INTER-HOSPITAL CUP TIE.

Played at Chiswick on Monday, June 19th, and unfortunately ended in our defeat by 3 wickets; a result mainly due to our lack of good bowling. No praise is too high for Wetherell's magnificent innings of 135, which included 12 fours and 9 threes; he batted during the whole innings, going in first and being last out. Brydone, Poyser, Bowle, Grellet and Langdale got into double figures, but 9 wickets were down for 150 when Strange came in, then occurred the longest stand of our innings, Strange keeping up his wicket and Wetherell hitting freely, 75 runs were added in an hour, at last Wetherell was bowled, and the innings closed for 225. Patterson and Mills bowled best. St. Thomas's started with Scott and Whitehead, the former was caught and bowled by Cowper at 24, and Badcock was sent back in the same manner by Wetherell at 62, then Whitehead and Harwood quite collared our bowling and added 100 runs for the next wicket. Harwood batted well for 51 and gave no chance. Whitehead had hard luck in not reaching three figures, being bowled for 92, he had given a very hard chance in the slips after making 23. Gostling and Hutton then hit off the runs. Wetherell bowled best for us, taking 4 wickets for 34. Scores:—

GUY'S.

G. S. Graham-Smith, b O. Mills	5
F. C. Wetherell, b E. V. Gostling	135
K. V. Trubshaw, b E. V. Gostling	1
J. M. Brydone, c Harwood, b T. W. Patterson	13
R. C. Poyser, b T. W. Patterson	17
H. M. Langdale, b O. Mills	11
G. T. Willan, b O. Mills	2

S. C. Bowle, c St. John Scott, b Hutton	10
H. R. Grellet, c Harwood, b T. W. Paterson	11
C. M. Cowper, b T. W. Patterson	1
E. W. Strange, not out	6
Extras	13
Total	225

ST. THOMAS'S.

St. John Scott, c & b Cowper	10
J. H. Whitehead, b Wetherell	92
L. H. Badcock, c & b Wetherell	17
H. M. Harwood, c Grellet, b Poyser	51
T. W. Paterson, b Wetherell	12
E. W. Hutton, not out	16
L. E. Hanbury, b Trubshaw	14
G. E. Adams, c Brydone, b Wetherell	2
E. V. Gostling, not cut	4
Extras	11
Total (7 wickets)	229

C. M. Bernays and O. Mills did not bat.

GUY'S v. EASTBOURNE.

Played on the Saffrons, Eastbourne, on June 23rd and 24th. Thanks to Harris's bowling we got rid of Eastbourne for 150; Matheson batted best for them, making 37 not out. We made 248, Harris again doing best with a fine innings of 85. Poyser also played well for 65. On Saturday our bowling was not so successful, and we were left with 216 runs to get, which was too much for us, Eastbourne winning by 53 runs, after Trubshaw and Grellet making a good effort to save the game. Scores:—

EASTBOURNE.

	1st Innings		2nd Innings.	
W. H. Andrews, c Grellet, b Graham-Smith	9	c Willan, b Harris	46	
Capt. Kaye, c & b Harris	23	c Poyser, b Cowper	21	
Rev. G. Cumming, c Cowper, b Harris	10	c Cowper, b Harris	14	
G. L. Whatford, c & b Harris	14	c G. Smith, b Harris	13	
J. A. E. Hickson, b Harris	1	c Palmer, b Harris	77	
C. Matheson, not out	37	c Bush, b Harris	58	
C. Blackett, b Harris	26	b Harris	4	
G. T. Turner, lbw, b Cowper	6	not out	29	
H. G. Goldsmith, b Cowper	0	b Poyser	22	
W. C. Holman, c & b Harris	0	b Poyser	4	
Shoosmith, b Harris	7	st Graham-Smith b Poyser	8	
Extras	17		17	
Total	150		313	

GUY'S.

	1st Innings.		2nd Innings.	
G. S. Graham-Smith, c Cumming, b Matheson	6	b Turner	10	
R. C. Poyser, c Cumming, b Kaye	65	b Matheson	3	
H. M. Langdale, run out	3	c Kays, b Turner	17	
S. C. Bowle, run out	0	c Goldsmith, b Turner	4	
G. T. Willan, b Shoosmith	35	b Whatford	6	
K. V. Trubshaw, lbw Matheson	26	not out	38	
Harris, b Whatford	85	c Andrews, b Kaye	17	
H. R. Grellet, b Shoosmith	4	c Hickson, b Whatford	30	
H. W. Bush, run out	0	b Shoosmith	4	
C. M. L. Cowper, not out	14	c Whatford, b Turner	14	
H. T. Palmer, b Whatford	0	b Shoosmith	4	
Extras	12		15	
Total	248		162	

Guy's Hospital Lawn Tennis Club.

PAST v. PRESENT.

Played at Honor Oak Park, on Saturday, June 17th. Play began with singles at 12 o'clock and at the lunch interval the Present were 2 up. This advantage was, however, soon lost and eventually the Past won by the odd event (7–8). For the Past F. E. Fremantle was in great form.

Singles.—H. B. Wedd lost to S. Reeves, 4–6, 1–6; E. N. Jupp beat B. F. Pendred, 6–4, 6–4; P. S. Mandy beat S. Pendred, 7–5, 6–3; H. K. Lacey beat C. E. Michael, 7–5, 6–2; H. Wacher beat F. E. Fremantle, 6–3, 6–1; F. B. Manser lost to A. A. H. Partridge, 4–6, 6–6.

Doubles.—Mandy and Lacey beat Michael and Partridge, 6–4, 5–7, 8–6: lost to Pendred and Pendred, 3–6, 7–5, 7–9; lost to Fremantle and Goodall, 4–6, 6–4, 3–6. Wacher and Manser lost to Freemantle and Goodall, 2–6, 4–6; lost to Pendred and Pendred, 5–7, 1–6; lost to Michael and Partridge, 3–6, 1–6. Wedd and Jupp beat Fremantle and Goodall, 6–1, 7–5; lost to Michael and Partridge, 5–7, 5–6, 1–6; beat Pendred and Pendred.

GUY'S v. ST. BART.'S.

The luck of the draw in the Inter-Hospital Cup Competition found us drawn against St. Bart.'s in the first round. At Chiswick, on Tuesday, June 20th, the St. Bart.'s six—a team above the Hospital average—disposed of the Guy's representatives by 8 matches to 3, 4 matches being left unplayed. Lacey and Jupp each captured a single, while Jupp and Wedd won a match in the doubles. Guy's might have annexed 3 more of the singles had their men been in better condition. The following six represented Guy's—P. S. Mandy, H. K. Lacey, H. Wacher, L. Cooke, E. N. Jupp and B. H. Wedd.

GUY'S v. CHISWICK PARK.

This match, played at Chiswick Park, on Saturday, June 24th, resulted, after a most enjoyable game, in the defeat of a weak Hospital six by 8 matches to 1. Chiswick Park, with their command over numerous class players, always manage to select a team just strong enough to comfortably dispose of the Guy's players. With Lacey and Wacher unable to play, all our pairs were weakened, Jupp partnering Mandy, and Manser and Pye-Smith coming in from the second. Mandy and Jupp were the only pair to win a match, though Cooke and Manser came near doing so. The following pairs represented Guy's—P. S. Mandy, E. N. Jupp; L. Cooke, F. B. Manser; B. H. Wedd, C. D. Pye-Smith.

GUY'S 2ND v. GIPSIES 2nd.

This return match was played at Honor Oak Park on Saturday, June 24th, in glorious weather. It was ex-

tremely unfortunate that in meeting such an exceptionally strong team four of our best men were away, as Wedd, Pye-Smith and Manser were playing for the 1st, and Fremantle was unable to leave the hospital, so consequently we were badly beaten. However, we had a very enjoyable game, and hope it will be an annual fixture. Result:—

J. S. Steele-Perkins and E. A. Ring lost to F. C. Clark and A. E. Sabey, 7–5, 3–6, 2–6; lost to A. W. Lavy and H. J. Lavy, 2–6, 1–6; lost to E. Goodall and E. S. Salter, 6–4, 4–6, 4–6. T. E. Holmes and Pollett lost to A. W. Lavy and H. J. Lavy, 2–6, 1–6; lost to F. C. Clark and A. E. Sabey, 0–6, 0–6; lost to E. Goodall and E. S. Salter, 4–6, 2–6. Wintworth and Shepherd lost to E. Goodall and E. S. Salter, 5–7, 6–8; lost to F. C. Clark and A. E. Sabey, 5–7, 6–8; lost to A. W. Lavy and H. J. Lavy, 0–6, 0–6. The Hospital lost, therefore, by 0 matches to 9, 2 sets to 18, 60 games to 122.

Guy's Hospital Bicycle Club.

The races for Mr. Golding-Bird's handsome Championship Cup were held on Tuesday, June 20th, at 5.30, on the Crystal Palace track. The races were one, five, and ten miles, and there were ten starters. J. E. L. Bates was the ultimate winner of the trophy, gaining the lowest possible number of points, and riding throughout in a superb manner which elicited rounds of applause from the spectators. R. May and A. M. Gabriel were evidently in splendid training, as was shown by the close fight they made. The results were—

ONE MILE.—J. E. L. Bates (1), R. May (2), A. M. Gabriel (3). Won by half a wheel. Time, 2 min. 10 sec.

FIVE MILES—J. E. L. Bates (who also scored most laps) (1), R. May (2), A. M. Gabriel (3). Time, 13 min. 5 sec. Easy win, inches only between second and third.

TEN MILES.—J. E. Bates (1), R. May (2). Time, 24 min. 15 sec. Won by over one hundred yards.

There was also a Novices' Race, open to members of the club, for a medicine case presented by Messrs. Burroughes & Wellcome. A very close and exciting race ensued among the numerous competitors, and the scratch man, J. Greenwood rode magnificently, and was beaten on the line by E. R. Lowe, after having made all the pace. Time, 5 min. 5 sec.

Mr. Golding-Bird, the president of the club, then presented the cup to J. Bates, and, in the course of a very characteristic speech, explained how he was trying to raise a cloud which had for so long hung over the Bicycling Club, by means of this trophy which was to be competed for annually, the winner to be champion for the year. He saw no reason why a club which had done such excellent work in inter-hospital sports should not have a cup of its own, and thus be on an equal footing with the Lawn Tennis Club.

The Palace grounds re-echoed with cheers for the keen and distinguished president, and thus terminated the first and highly successful meeting for the Championship Cup.

United Hospitals' Rifle Association.

UNITED HOSPITALS' RIFLE ASSOCIATION
v.
HONORABLE ARTILLERY COMPANY.

This match was shot at Ilford on Tuesday, June 13th, 1899. Teams:—

U.H.R.A

	200	500	600	Total.
Pt. Carpmael, St. Thomas's ...	33	31	28	92
Corpl. Read, St. Bart.'s	33	34	25	92
Pt. De Morgan, St. Mary's ...	26	29	25	80
Pt. Gandy, St. Bart.'s	32	25	22	79
Pt. A. C. Brown, St. Bart.'s ...	28	23	19	70
Pt. Weeks, St. Bart.'s	23	22	18	63
			Grand total	476

H.A.C.

	200	500	600	Total.
Capt. Carpenter	30	30	30	90
Pt. Trask	32	28	33	93
Pt. Hizzard	29	32	30	91
Sergt. Duncan	33	31	26	90
Bomb. Mate	30	33	26	89
Staff-Sergt. Kent	25	28	35	88
Counted out—			Grand total	541
Pt. Glanville	31	29	23	83
Major Monday	31	28	23	82

The United Hospitals lost by 65 points. The United team was two short, so the H.A.C. very courteously agreed only to count the best six scores.

Births.

CLARKE.—On June 10th, at Windsor House, Morley, the wife of W. Travers Clarke, M.R.C.S., L.R.C.P. Lond., of a daughter.

COLEMAN.—On June 18th, at Sudeley House, Sutton Bridge, the wife of J. G. B. Coleman, M.R.C.S., L.R.C.P. Lond., of a daughter (Kathleen Blyth).

WAINEWRIGHT.—On June 15th, at 49, Wickham Road, Beckenham, Kent, the wife of Robert S. Wainewright, M.D. Lond., of a daughter.

WASSON.—On June 20th, at 64, Burgoyne Road, Harringay Park, N., the wife of Richard Llewhellin Wasson, of a son.

Marriage.

SCOWBY—SKELTON.—On June 8th, at St. Andrew's Church, Sheffield, by the Rev. Charles Steele, Edward T. Scowby, M.B., of Selston, Notts, to Julielma, elder daughter of Sir Charles Skelton, Meadow Bank, Sheffield.

Death.

SLATER.—On June 14th, at Northampton Hospital, Leonard Slater, M.A., M.B., of Osman House, Fortis Green, London, N., aged 31 years.

ED.—H. L. E.

Contents.

	PAGE
PERFORATED GASTRIC ULCER: Clinical Lecture by Dr. Shaw	285–292
HOSPITAL NEWS	292–295
CASE FOR DIAGNOSIS	295–296
NURSING NOTES	296
GUY'S HOSPITAL DEBATING SOCIETY	296
PASSIM	297–298
NURSING NEWS	298
PRIZE DAY, 1899	299–303
THE UNITED GUYITE CLUB OF 1868	303
IN LIGHTER VEIN	303–304
GUY'S HOSPITAL CLUBS' UNION	304
PASS LIST	304
APPOINTMENTS	304
SPORT: The United Hospitals' Athletic Sports. Cricket—Guy's v. Reigate Priory; Guy's v. Brentwood. United Hospitals' Rifle Association. Guy's Hospital Lawn Tennis Club—Inter-Hospital Junior Lawn Tennis Tournament—First Annual Meeting; Guy's v. Staff. United Hospitals' Swimming Meeting	305–308
PAPERS BY GUY'S MEN	308
FROM THE GAZETTE'S SPECIAL PATHOLOGIST	308

Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well as subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

The charge for binding in blue, with the Arms of the Hospital in gold will be ONE SHILLING AND SIXPENCE.

Calendar of Coming Events.

July, 1899.

Sat. 15.—Annual Dinner of Debating Society.
G.H.B.C., Inter-Hospital races at Sheen House.
G.H.C.C., I., Dunstable Grammar School, away.
II., Old Dunstonians, home.
G.H.L.T.C., I., Connaught, away.
II., Surbiton, home.

Mon. 17.—Preliminary Scientific M.B. Lond. Examination begins.

Tues. 18.—Guy's Hospital Missionary Society Meeting at 8. Speaker: Rev. C. H. Andrews, of Delhi.

Wed. 19.—School Examination in Elementary Anatomy.
G.H.C.C., II., Christ's College, Finchley, away.
G.H. Polo Club, City of Westminster, home.
Clinical lecture by Dr. Washbourn.

Thur. 20—Mr. Golding-Bird's take-in; Drs., R. Lilbury and H. McD. Parrott; Cl., G. S. Simpson.

Sat. 22.—G.H.L.T.C., I., Wanstead, away.
II., Putney, home.

Mon. 24.—Examinations for Junior and Senior Prizes for General Proficiency and for the Beaney Prize in Pathology.

Tues. 25.—First Conjoint Examination begins.
Lectures cease.

Thur. 27—Mr. Howse's take-in; Drs., J. H. Glover and J. M. Brydone; Cl., F. O. Stoehr.

Guy's Hospital Gazette,

JULY 15, 1899.

Perforated Gastric Ulcer.

CLINICAL LECTURE BY DR. SHAW.

June 14th, 1899.

GENTLEMEN,—A week ago to-day there was admitted into John ward a patient who, a few hours before his admission, was performing his laborious occupation as a coal-heaver, apparently in good health. As a matter of fact he was suffering from a latent disease, which in a few moments, owing to a slight extension of the mischief, caused him to be in the most intense agony, and placed him in imminent peril of his life. He was suffering from a gastric ulcer, and the added condition which led to this danger was the perforation of its base, which established a communication between the stomach and the general peritoneal cavity.

I hardly know any condition in which greater progress has been made in treatment, during the time I have been a student of medicine, than in that of perforating gastric ulcer. Many years ago, when I was a ward clerk, I remember listening to a lecture by the late Dr. Hilton Fagge upon a fatal case of this sort. Dr. Fagge was a very impressive lecturer, and he impressed me very much by the way in which he urged upon us the importance of what was then practically a novel treatment of perforated gastric ulcer, the withholding of all food from the stomach, and feeding the patient entirely by the rectum. He related a case to us in which it seemed probable that a patient had by this treatment had her life saved temporarily, but who some months afterwards died of acute peritonitis, which was found to be due to the perforation of a second gastric ulcer. That was almost the only case which Dr. Fagge could tell us about in which a patient had probably recovered from a perforating gastric ulcer. To-day I am able to bring before you four cases, all of whom I saw when they first were admitted to the hospital within the last eighteen months, suffering from perforating gastric ulcer. They have all survived the accident, three of them having completely recovered, while the fourth case, which is the one that has induced me to use the subject for a clinical lecture, is in a fair way to recovery. I believe I am also right in saying that these are the only cases of perforating gastric ulcer with which I have had anything to do in the last two years.

I am quite prepared to admit, however, that we had very great luck. We were particularly fortunate in that in every one of these cases we were able to learn facts in the previous history which helped us to come to an accurate and early diagnosis. We were also peculiarly fortunate in that three of the cases came under treatment at the very earliest stage of the disease, and in a condition in which their symptoms had not been already masked by any sedative treatment. Cases of this sort, in which you snatch the patient from almost certain death, are always very interesting, and therefore I have no hesitation in bringing these four cases fully before you. In order that you may more readily grasp their resemblances and differences, I have tabulated on the board behind me some of the most important facts in each of the four cases (see Table).

The first case (No. 4 on the table) is that of the man who came in this day week, who is still lying not absolutely free from danger, in No. 9, John ward. He was a coal-heaver. I should like to remind you with regard to the history which I am going to read, that a good deal of it, as stated by the clinical assistant, was obtained after the patient's recovery from his operation. You can hardly expect to get from a patient who is in the condition that this man was in, a very clear statement as to what happened to him before. All that the poor fellow could say, referring to his pain, was, "Oh, it is great!" So that you must not imagine that we knew as much about the patient before we were called upon to make a diagnosis, as we did after he was operated upon.

About seven or eight years ago he was a healthy man, but began to be dyspeptic, and had pain across the upper part of the abdomen after meals. The dyspepsia got worse, and ultimately was present more or less all day. Vomiting occurred recently about twice a day. There is no history of hæmatemesis or melæna. The present attack began at seven o'clock this evening. The man was walking out of the stable after attending his horses, when he was taken with pain in the upper part of the abdomen, and fell down, and lay doubled up. His friends put him on a dray and brought him to the hospital. He vomited once slightly on admission. At four o'clock in the afternoon he had his last meal, a cup of tea and a tea-cake. He had gone without his dinner, and this he attributed to pressure of work, and not to any loss of appetite or special pain.

On admission.—"His tongue was furred and his skin moist, and his bowels regular. He has vomited once since the present attack. He has been suffering continuous severe pain, which is not relieved by pressure, nor much increased, perhaps on account of its intensity. That is a correct remark, I think; it would have been very difficult to increase the pain this man was suffering. "His respiratory movement is restricted to the upper part of the abdomen. There is rigidity here, and to a less extent in the lower part. The whole of the abdomen is resonant, the liver-dulness is normal."

Having got so far as that, we made up our minds that we had probably got a case of perforating gastric ulcer, and asked Mr. Symonds to operate upon him. "At 9.50, two hours and fifty minutes after perforation, his abdomen began to be opened. Mr. Symonds made an incision from the ensiform cartilage to the umbilicus, and it was found that the peritoneum was blown up with air underneath it. When opened there was an escape of gas. Some fluid with some small solid particles also escaped, and there were some of these also in the peritoneal cavity. On exploring the stomach, gas was seen to be bubbling out of a small round hole, a quarter of an inch in diameter, in the anterior wall close to the pylorus. After this was closed by sutures the stomach was still distended with fluid and gas." Mr. Symonds was rather afraid that in suturing the ulcer which was just at the pylorus, he might cause pyloric stenosis, so to settle this point and also to relieve tension, the stomach was incised in its anterior surface and the gastric contents evacuated. The abdominal cavity was then thoroughly flushed out with sterile water, and a piece of omentum was brought over the sutured openings in the stomach to prevent any leakage taking place afterwards. Since the operation the patient has been pretty well. He has given us some anxiety, having vomited once or twice, and his temperature having risen on the first, second, and third day after the operation, but he has not had any serious abdominal pain, and we hope he will ultimately recover.

I will refer much more briefly to the three other cases. They are not strictly in chronological order, but I wanted No. 1 to be separated from Nos. 2, 3, and 4, it having some rather different features.

No. 1. was the case of a young woman, twenty-one years of age, a factory girl, who was admitted in March, 1898. She said she had three quarts of hæmatemesis in December, 1896. She was then perfectly well until about a month ago. During the last month she has had dyspeptic pain, but went to bed in good health on

Table Illustrating Clinical Lecture on Perforated Gastric Ulcer.

Sex.	Age.	Previous gastric history.	Time of last meal before onset of acute symptoms.	Interval between accident and laparotomy.	Situation of ulcer.	Treatment of ulcer.	Treatment of peritoneal cavity.	Duration of convalescence.	Symptoms during convalescence.
(1) F	20	Profuse *hæmatemesis* 15 months ago; gastric pain during last month	Supper 3 or 4 hours before	60 hours	Lesser curvature anterior surface	Sutured and covered with omentum	Flushed and drained with tampon	2 months	Vomiting, diarrhœa, short periods of high fever, severe bronchitis, peritoneal rubs on spleen, albuminuria.
(2) M	38	Indigestion for 6 months; no hæmatemesis or melæna	Breakfast 4 or 5 hours before	5¾ hours	Anterior surface, close to pylorus	Sutured and covered with omentum	Flushed: counter opening and drainage with 2 tubes	1 month	First 2 days vomiting, temperature 100° on second day, no bad symptom after.
(3) M	43	"Nervous dyspepsia" at intervals for 2½ years; last attack 3 months' duration; no hæmatemesis or melæna	Breakfast 6 hours before	8 hours	Anterior surface, close to pylorus	Sutured and covered with omentum	Flushed: counter opening and drainage with 2 tubes	1 month	None. Operation appears to have cured "nervous dyspepsia."
(4) M	43	A dyspeptic for 7 or 8 years; worse last 2½ years; vomiting frequently; no hæmatemesis or melæna	Tea 3 hours before	2 hours and 50 minutes	Anterior surface, close to pylorus	Sutured and covered with omentum	Flushed and completely closed	In progress now 7 days	Vomiting first 2 days, abdominal pain slight, temperature 100°.

March 21st, at 11 o'clock. At 1 a.m. she aroused her mother by screaming, and her mother found the girl kneeling up in bed doubled up with pain. The pain subsided after a poultice was put on. The young woman was sick again at 2 a.m., and again next morning, on the second occasion bringing up blood-stained vomit. On the 23rd she came downstairs and took some jalap which caused increase of pain. On the 24th she was better, so she walked to Brockley Station (ten minutes from her house), and then came to Guy's Hospital, bringing a bottle "to take away some medicine." On admission her pulse was 112, she had a distended abdomen, which was characterised by board-like rigidity; the liver dulness was present, and rubs were heard over the liver and spleen. I do not quite gather what time she arrived at the hospital. Mr. Symonds started to operate at two o'clock in the afternoon. On opening the abdomen a foul collection of pus was found. I was called to see this case in Dr. Goodhart's absence. By the time the operation had begun Dr. Goodhart was there, and on account of the fœtor which came when the abscess was opened, Dr. Goodhart expressed the opinion that we had not got to deal with a gastric ulcer, but with an abscess connected with the appendix. However, as events turned out, this was not so, for during the washing out of this abscess in front of the abdomen, a great gush of gas began to pour out into the cavity. This was discovered to be coming from a hole in the anterior wall of the stomach. This ulcer was found near the lesser curvature, on the anterior surface. The peritoneal cavity was flushed out, and the wound closed above, but a gauze drain left below. Afterwards, her progress was very slow. There were vomiting, diarrhœa, bursts of high temperature, which made us very anxious; there was also troublesome bronchitis, rubs were heard over the spleen, and albuminuria was also present. Nevertheless, she made a complete recovery, and was discharged from the clinical ward two months after admission.

We now come to case No. 2. a man, another coal-heaver, who came in on February 23rd, 1898. The history states: "For the last six months he has suffered from indigestion. He had never had any melæna, or hæmatemesis, or jaundice, or hæmaturia, or anything whatever to do with lead. When he got up on the morning of admission he had slight pain on the right side. He went to his work, and was engaged in shovelling coal when, at about 11 o'clock, he was suddenly seized with acute abdominal pain, agonising in its intensity. He had violent retching soon after the pain came on, but did not bring anything up. In half an hour a doctor saw him, who is said to have told the patient he had wind, and ordered him to go home in a cab, and call at the hospital on the way. He was seen here at 3.30 in the afternoon, and was in the greatest possible pain at the time. His legs were drawn up, his temperature was normal; pulse 96, regular and full; respiration 52. The abdomen moved on respiration, was very rigid and excessively tender, the tenderness being slightly more marked above than below; the liver dulness was normal." We saw him, as I have said, at 3.30, and Mr. Dunn begun to perform laparotomy five and three-quarter hours after perforation. On incising the peritoneum, gas escaped, and also a turbid, milky fluid containing solid particles. The stomach was pulled up and an opening one-eighth of an inch in diameter was found on the anterior surface close to the pylorus. The opening was closed by sutures, a portion of the great omentum was brought over the wound, and the peritoneal cavity was thoroughly flushed out. Food was found between the liver and diaphragm, and also in the pelvis. A counter incision was made above the pubes, and tubes were put into the original incision and also in the counter puncture. For the first two days afterwards the patient had occasional sickness, and on the second evening his temperature was 100°. He was discharged four weeks after the operation. Mr. Dunn tells me he saw the patient the other day in perfect health.

The last case, No. 3 on the table, is that of a man, aged forty-three, a merchant in the City. He was admitted on July 30th, 1898. "In April, 1896, he had been suffering from general lassitude, pain in the stomach after food, and nausea. He consulted a physician who said he had no organic disease, but was suffering from nervous dyspepsia. In June he began to vomit after meals a fluid which never contained blood. Further consultation confirmed the original diagnosis, and in August he went to Egypt till October. Here he completely recovered, and enjoyed excellent health till April, 1898. Then he began to have indigestion again, with abdominal pain having no relation to food. This continued, more or less, till the day of his acute illness. He lived a little way down the South Eastern line, and used to come up to business every morning. He was in the habit of riding from the station to his business. One morning, while riding on his bicycle, he had such severe abdominal pain that he found it absolutely necessary to get off his machine.

In three minutes he was better and able to continue his ride. He came up to the City and transacted his business, but took no food. In going home he went up to London Bridge, and while waiting for the train he was suddenly seized with such severe abdominal pain that he was carried by a porter to Guy's Hospital, where he was first seen at 3 o'clock in the afternoon. He was in great agony, rolling from side to side, with his legs drawn up. The abdominal wall was as hard as a board all over, and there was extreme tenderness, chiefly on the right side. The abdomen did not move on respiration, the liver dulness was normal, temperature 98·4°, pulse 100, respiration 26. The patient was constantly vomiting small quantities, one ounce at a time, without any blood. Morphia was given to him in the surgery." I did not see him till 9 in the evening, and I then immediately arranged with Mr. Dunn to operate. He started the operation at 11 o'clock, that is, eight hours from the time of perforation. We found a button-hole opening in the anterior wall, close to the pylorus. In fact, in each of the three male cases the appearances at the operation were almost identical; the hole was of the same size and exactly in the same situation. This hole was sewn up, and a counter opening made above the pubes; the peritoneal cavity was flushed out and tubes left in. There was never the least check towards recovery, and this patient is now perfectly well.

Now I should like to put together the symptoms which make up a composite picture of our four cases. First, in all of them there is sudden onset of most severe abdominal pain. Every one of them seemed to agree that it was the worst pain they ever had in their lives. If you enquired after their previous history they could tell you very little about it, our last patient, whose case I first related, and who had such a long previous history of vomiting and pain, would not admit that he ever had abdominal pain before, the memory of every other pain having been obliterated by this last seizure. As a matter of fact, after my first interview I left him under the impression that he never had had any dyspepsia at all.

They mostly seem to agree that the pain is in the upper part of the abdomen. But I should advise you not to lay too much stress upon the situation in which the pain comes on. The pain is accompanied by nausea and vomiting. In some text-books on perforating gastric ulcer, they tell you that the patients do not vomit. There seems to be an idea that as there is a hole in the stomach, if the stomach were to contract and try to expel its contents in the ordinary way, these would be sent out by the hole, but of course this is not so. The patients vomit not because of the condition of their stomachs, but of their peritoneum; they vomit in the same way as a person who has a perforated or strangulated intestine, as the result of serious interference with the nerves of the peritoneum.

The pain is generally described as constant, but it may come on in paroxysms. I shall never forget going round the wards with one of our former physicians, who, drawing our attention to a patient who had come in with severe, sudden, paroxysmal pain, particularly asked us to notice that when we came up to the bed the patient was lying evidently not in pain. But while he was talking about it to us she was suddenly seized with a paroxysm of pain. "You notice, gentlemen," said the physician, "that this patient's pain is paroxysmal. That is characteristic of colic; you never see paroxysmal pain of this nature in cases of peritonitis due to perforating ulcer." The next afternoon I saw the post-mortem, and the cause of death was general peritonitis from perforating ulcer of the stomach. This shows you it is not safe to say that pain with gastric ulcer will not be paroxysmal. Why should not it be? If there is an opening between the peritoneum and the stomach, the gastric juice does not all go out at once. As peristalsis takes place, more and more of the contents of the stomach is passed out, and each access of material forced into the peritoneal cavity gives rise to a paroxysm of pain.

Pain is usually accompanied by tenderness, and is worse on pressure. In our first case pain was not made worse by pressure, for reasons I have already suggested.

Another symptom. The abdomen is very rigid. In most reports I think the word "boardlike" is used. You must always be a little careful about custom and fashion in these terms. It is rather the fashion to say that the abdomen of a patient who we know has peritonitis is boardlike, just as it is the custom to say, "He has a wiry pulse." However, I want you not to be too much committed to expressions of that sort.

The pulse may be very little affected; eighty or ninety may be the rate of it. The later the case you have to deal with, the more rapid will be the pulse.

In every one of our cases liver dulness was present. It is looked upon as a most characteristic feature that the liver dulness will be absent, but it is certainly not often absent in the early

stages. The absence of liver dulness is due to the fact that gas has got out into the general peritoneal cavity, and the amount of gas required to keep the liver away from the abdominal wall is very great. By increase of gas, as time goes on, liver dulness may disappear, but not early. In the most advanced case, the woman who walked up to the hospital, we heard peritoneal rubs over her liver and spleen. It would not have been so if the perforation had just newly occurred.

In every one of the cases there was a history of previous indigestion. This history may be absent, not only because the patient is too ill to remember slight ailments, but because gastric ulcer may exist without any symptoms whatever.

Now, I want you to note in these four cases, especially the three last ones, the absence of some of the classical symptoms mentioned in all the text-books. The reason is that the picture of perforating gastric ulcer, as described in the text-books, is taken undoubtedly from patients, not in the first few hours, but in the second or third day of the disease, when, in fact, they are not suffering with perforated gastric ulcer, but dying from its effects. Therefore, if you are going to wait until the classical symptoms develop themselves, then you will undoubtedly wait much too long.

What are these classical symptoms? First there is very great collapse. The patient will have a clammy skin, a white face, a typical abdominal face, with a sunken appearance in the eyes which is very characteristic, but is not often developed so early as I want you to diagnose gastric ulcer; rapid, wiry pulse, a dry, brown tongue, resonance over the liver in front, and dulness in the flanks. Many of these symptoms are not to be found in cases of perforating gastric ulcer at a time when you may hope to cure them by surgery. Just in as far as we attempt to make a diagnosis in these earlier periods, so we add to our difficulty in diagnosis.

I should like you to consider with me the conditions from which we must endeavour to differentiate a perforating gastric ulcer. Whenever the physician asks the surgeon to operate for him in these days of high aseptic ritual, there is always a considerable interval between the moment that the operation has been determined upon and the moment that it begins, and during that interval the surgeon's usual way of entertaining the physician is by describing to him the large number of cases in which he has been asked to operate for various supposed conditions that were not found.

I will enumerate some of those things that you might mistake. First of all, remember that colics of all sorts may undoubtedly be mistaken for perforating gastric ulcer. Gastric colic, intestinal colic, appendicular colic, renal colic, hepatic colic, and fallopian colic may all be mistaken for perforative peritonitis. Very much depends upon the severity of the pain. But just as you cannot tell whether a patient is conscious or not except by his capacity of expressing his consciousness to you, so you cannot tell how severe is his pain except by the way in which he expresses it. Some people with the slightest little stomach ache will keep a whole house awake all night with their roars, and other people will allow themselves to die of perforating gastric ulcer, and say nothing about it.

Foremost of all colics I should like to remind you of lead colic—not that it is often so bad as to make you think of perforating ulcer. You have heard, perhaps, of an old lady who went into a hospital—not Guy's—with what was supposed to be the fifth attack of lead colic, a poor old woman who had to work amongst lead and could not afford to give it up. She had very bad vomiting, more than she ever vomited before, and her constipation was more difficult to overcome than ever. All their efforts failed to overcome these symptoms, and post-mortem it was discovered that she had got a strangulated femoral hernia. Do not assume, therefore, that because your patient has got a blue line on her gums that she is necessarily suffering from lead colic. Nor must you assume that because a patient has no knee-jerks that his abdominal pain is a "gastric crisis" of locomotor ataxia. But do not fail to investigate the gums and the knee-jerks of every case of sudden gastric pain.

Then I very strongly warn you against pain from pulmonary conditions. I have seen cases in which perforating gastric ulcer has been strongly suspected, but in which the origin of the pain was an acutely inflamed condition of the diaphragm. One of the tales that the surgeon regaled me with, last Wednesday night, was a case in which he had been asked to operate, but subsequently it was agreed that the operation might be postponed till next morning, and next morning they found that the patient was suffering from acute lobar pneumonia. I remember being told by Dr. Fagge when children come as out-patients, with pain in their stomachs, to be quite sure that they have not got pleurisy, which is very likely to give rise to severe pain in the region of the umbilicus.

There is another condition which you must endeavour to distinguish. One of our surgeons told me he had operated on his seventh case of the kind. The other day, thinking he had got something in the nature of perforating ulcer to deal with, he operated and discovered that it was a case of acute pancreatitis. This is a disease which undoubtedly is exceedingly difficult to distinguish from perforating gastric ulcer. Acute intestinal obstruction is also very difficult to distinguish from this condition.

We now come to the last group—perforation of any other hollow viscus, traumatic or non-traumatic. You have practically the same symptoms, whether the ulcer is in the stomach or the duodenum. I do not imagine you could ever, without an operation, tell the difference between perforation of a gastric or duodenal ulcer; nor does it matter in the least, for the progress and treatment of the two are identical. Perforation of the appendix, or ileum, or ruptured pyonephrosis have very carefully to be distinguished from gastric ulcer; because you are much more likely to operate satisfactorily if you suggest to the surgeon which of these exists, in order that the abdominal incision may be made in the most convenient situation.

Now for a few points in the pathology of perforating gastric ulcer. First of all, what does the term *(perforating gastric ulcer)* mean? Strictly speaking, I suppose everybody will admit that a perforating gastric ulcer is one that goes right through the stomach wall. But that is not what the term is generally understood to mean. By this term is commonly understood a form of perforation which goes right through the stomach, and causes a communication between the stomach and the general peritoneal cavity. In talking to you of some of the conditions of perforation, I am going to use the term in the sense in which all the coats of the stomach are destroyed by the ulcer, whether the peritoneal cavity is opened or not.

Why is it that ulcer of the stomach perforates so readily? We do not know yet why it is that the ulcer forms; I do not think we have any satisfactory explanation of the causation of gastric ulcer. But although we do not know why it forms in the first place, I think we are right in believing that gastric digestion has something to do with the extension of the ulcer. That seems absolutely certain because of the special features of the ulcer as it appears, first, in the stomach, secondly, in the duodenum, and lastly, in the œsophagus. These are the three parts to which the gastric juice is able to get access, and in each of these parts you find the ulcer differs from an ulcer in any other part of the body. So that there can be no doubt that the gastric solution has a very important bearing on the pathology of this ulcer, and probably also on its perforation.

All active ulcers tend to go deeper, but there is the added fact that a gastric ulcer is always bathed in a fluid which has the power of solution.

I should like to classify for you the perforating ulcers. First, I want you to remember that there is a form of perforating ulcer which you must call acute perforating gastric ulcer. It is one in which it appears that from the moment the process of destruction starts, the ulcer, with absolutely no check, goes straight through every portion of the wall of the stomach until it comes out on the other side through the serous membrane. I have an impression that that kind of thing might happen in two or three days, I had almost said twenty-four hours—I do not know. These are cases in which there is no previous history of indigestion to help you in your diagnosis.

This class of case is peculiarly liable to occur in young women. If you take the reports of some hospitals you will find a great many more of these cases than in other hospitals. With regard to hospitals in the west end, for instance, the patients with this disease are principally women, whereas at Guy's the majority of the cases of gastric ulcer are men. That is to be explained by the large number of servants who get into west end hospitals; while here we have factory girls, there are no residential parts from which we could get domestic servants. Why should domestic servants get gastric ulcer? Perhaps it is attributable to the different diet which they get in the houses of their masters to what they have been in the habit of taking before they go into service. This ulcer has a peculiar punched-out appearance, which is said to be so characteristic of it. That is the acute perforating ulcer without adhesions.

Then there is the chronic perforating ulcer without adhesions, one which advances slowly until the serous coat of the stomach gives way, and then the communication is established.

Next, there is chronic perforating ulcer with adhesions, which is, perhaps, the commonest kind. As the ulcer makes its way to the serous coat, the serous coat becomes inflamed, and as the coat is in contact with something else it becomes glued on to it; adhesions form, and when perforation has taken place, the hole is

blocked up and communication with the peritoneal cavity is prevented.

When a chronic perforating ulcer has formed adhesions, one or two things may happen. It may become detached. I have rather a suspicion that case No. 3 was an example of the condition in which the chronic ulcer had become attached on to something, and then separation had taken place. I imagine that as the patient was bicycling on that morning after breakfast, a partial detachment of the ulcer took place, and a small quantity of the contents of the stomach came out, and then later on in the day the detachment became complete. Or a chronic perforating ulcer having become attached to some neighbouring viscus, the process of extension may go on, and then all sorts of things happen. To these I will refer in a moment. First, I want to draw your attention to what happens when any sort of perforating ulcer opens into the peritoneal cavity. The commonest result is general peritonitis, but sometimes the peritonitis becomes localised. This chiefly depends on the situation of the ulcer. If the ulcer is behind the stomach it will generally give rise to localised peritonitis; if it is in front it will most likely give rise to general peritonitis. A localised peritonitis not uncommonly gives rise to a form of abscess which is known as subphrenic empyæma.

Now, I want to point out what may happen when the ulcer has become adherent to some neighbouring viscus, and extension has taken place *not* into the peritoneal cavity. It may open into the intestine, and you get a gastric, a duodenal, or any sort of fistula. Sometimes a perforating ulcer has glued itself on to the liver, and extended into that organ, and formed a great abscess cavity in it, and then very likely it will set up that form of thrombosis of the portal vein known as suppurative pylephlebitis.

It is not uncommon for these ulcers to make their way into the pancreas and open the pancreatico-duodenal artery, causing fatal hæmorrhage. Or they may open into the pleura and cause basal pleurisy. The text-books give you indications for diagnosing the advent of gastric ulcer into the pericardium. It sometimes happens that these ulcers glue themselves on to the pericardium and find their way into the heart, and there is a communication established between the left ventricle and the stomach. It is not at all uncommon for the extension to be in the direction of the retro-peritoneal connective tissue. Then, abscesses may burrow down behind the abdomen and open underneath Poupart's ligament.

Now, you will see a perforating gastric ulcer, using the term in its extended sense, may do a great many things, quite apart from the way in which it may perforate into the general peritoneal cavity, and quickly kill the patient. As a matter of fact, if it does open into the general peritoneal cavity and kill the patient, the text-books are pretty uniform in their opinion that death will be very rapid. Tales are told of patients who fell down dead suddenly with perforating gastric ulcer. I do not think that perforating gastric ulcer itself would kill so suddenly; in such cases there has probably been some cardiac defect. But at the outside they will give the patient three or four days to live.

Our responsibility in recognising the condition early is, therefore, very great indeed. If these cases I have recorded to you to-day will help you to do that in your practice afterwards, and so save some people's lives, we shall feel that we have not spent this hour unprofitably. If I have so impressed upon you the importance of early recognising gastric ulcer, and of early operation, that it leads you sometimes to operate on cases unnecessarily, I hope that the aseptic principles which you have learned at Guy's Hospital will prevent you from doing your patient any serious injury; and I shall not mind an occasional accident of this sort, if your promptness in dealing with such cases leads you to save the lives of some who, having suffered from perforating gastric ulcer, would otherwise almost certainly have died in the course of a few hours.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

CASES UNDER DR. PYE-SMITH.

MARY	25.	Mitral regurgitation.
	26.	Erythema nodosum.
	27.	Osteo-arthritis.
	28.	Hæmatemesis. Gastric ulcer.
	29.	Empyema. Operation.
	30.	? Cerebellar tumour.
	32.	Acute nephritis.
	33.	Pleuritic effusion after pneumonia.
	36.	Hæmaturia.
	37.	Mitral stenosis.
PHILIP	21.	Mitral regurgitation. Chronic nephritis.
	22.	Icterus. ? Gall stones.
	23.	Tuberculous peritonitis.

PHILIP 25, 37. Acute nephritis.
26. Mitral regurgitation and stenosis.
27. Gout. Chronic interstitial nephritis.
28. Glycosuria. Old phthisis of left apex. Peripheral neuritis.
30. Progressive muscular atrophy.
31. Malignant growth of colon. Colotomy.
32. Abdominal tumour.
33. Mitral regurgitation.
34. Pyelitis.
35. Pleurisy.
38. Chorea. Mitral regurgitation.
40. Mitral and aortic regurgitation.

CASES UNDER DR. TAYLOR.

MARY 38. Neuritis.
39. Enlarged liver. ? Malignant disease.
40. Exophthalmic goître.
43. Phthisis.
45. Gastric ulcer.
47. Duodenal ulcer.
48. Abdominal tumour.
50. Chorea.
Cot 56. Broncho-pneumonia.
57. Broncho-pneumonia.
STEPHEN 1. Pleuritic effusion.
2. Ascites.
3. Epistaxis. ? Cirrhosis.
4. Acute rheumatism.
5. Empyema.
7. Dilated heart.
9. Diabetes.
10. Pleuro-pneumonia.
11. Gastric ulcer.
12. Bright's disease.
13. Typhoid fever.
14. Phthisis.
15. Acute rheumatism.
17. Diabetes mellitus.
18. Pneumonia.
19. Locomotor ataxy.
20. Appendicitis.

CASES UNDER DR. HALE WHITE.

MARY 13. Chorea.
14. Gastric ulcer.
15. Apical pneumonia.
16. Acute phthisis.
17. ? Infarction of spleen. Mitral stenosis.
20. Granular kidney.
22. Cerebral tumour. Trephined.
23. Osteo-arthritis.
Cot 54. Aortic stenosis. Mitral stenosis and regurgitation.
PHILIP 1. Sciatica.
3. Multiple sarcomata.
4. Aortic regurgitation and stenosis.
5. Dilated tubes. ? Bronchitis.
8. Gout.
9. Empyema.
PHILIP 10. Chronic peritonitis.
11. Diabetes mellitus.
12. Carcinoma ventriculi.
13. Granular kidney.
14. Tonsilitis.
15. Phthisis. Lardaceous disease.
18. Rheumatic arthritis.
20. Dilated stomach.

CASES UNDER DR. PITT.

MARY 1. ? Infective endocarditis.
3. Acute rheumatism.
6. Cirrhosis of liver. Large amount of ascites.
7. Appendicitis. Operation.
10. Mitral systolic, and mid-diastolic bruits. Ascites. Rheumatism.
11. Multiple synovitis.
12. Empyema.
STEPHEN 21. ? Spinal caries. ? Abdominal aneurysm.
22. Bronchiectasis.
25. Pneumonia.
28. Pleurisy.
29. ? Tubercular kidney. ? Malignant.
30. Pneumonia. Anti-pneumococcin.
32. Acute eczema.
33. Chorea. Adult.
35. Cerebral thrombosis.
40. Alcoholic gastritis.

"Clinical."

2. Cerebral hæmorrhage.
3. Aortic stenosis and regurgitation. Angina.
4. Secondary malignant liver.
6. Perinephritic abscess.
7. Pleurisy.
8. ? Corrosive poisoning.
9. Perforated gastric ulcer. Operation. Recovery.
10. Abdominal abscess.
11. Old empyema.
12. Icterus.
13. ? Gastric carcinoma.
14. Fœcal impaction.
18. Mitral disease.
19. Double mitral and double aortic disease.
21. Pericarditis.
22. Pyæmia.
23. Phthisis. ? Addison's disease.
25. Ovarian cyst.
26. Cerebro-spinal meningitis.
27. Malignant growth of sigmoid.
28. Hydatid cyst of liver. Perforating into lung.
29. Gärrtner's disease.
30. Pericarditis with effusion.
Cot 33. Broncho-pneumonia.
34. Diphtheria.

In the Surgical Wards.

Cases under Mr. Howse.

Naaman
3. Syphilitic testis and hydrocele. Castration.
4. Old excision of tuberculous hip with sinus.
5. Tuberculous tarsus. Scraped.
6. Tuberculous knee.
8. Spinal caries. Double iliac abscess. Incised.
9. Sarcoma testis. Castration.
10. Cancer of rectum. Inguinal colotomy.
11. Caries of ribs. Pectoral abscess. Incised.
12. Tuberculous knee. Arthrotomy.
13. Appendicular abscess. Fæcal fistula.
15. Hammer toes. Amputated.
16. Empyema. Previous drainage. Ribs resected.
17. Multiple painful lipomata.

Dorcas
1. Æt. 4. Fractured femur. Double Bryant.
2. Corns.
3. ? Renal calculus. Nephrotomy.
4. Strangulated femoral hernia. Kelotomy.
5. Fractured left femur. Hodgen. Fractured right tibia and fibula.
6. Gummatous ulceration over and arthritis of elbow.
7. Vesical calculus.
8. Carcinoma mammæ. Excised.
9. Iliac abscess. Incised.
11. Strangulated femoral hernia. Kelotomy.
12. Moveable kidney.
13. Fractured femur. Hodgen.
14. Carcinoma mammæ. Excised.
15. ? *Tuberculous.* ? *Syphilitic arthritis* of knee. Amputation through thigh.
16. Submandibular cellulitis. Incised.
17. Acute mastitis.

Astley Cooper
1. Ruptured urethra. Perineal section.
2. Compound fracture tibia and fibula. Wired.
3. Ruptured eyeball. Excised.
6. Fractured ribs.
7. Crushed hand. Amputation through forearm.
9. Fractured femur.
23. Cut on thoracic wall. Non-penetrating.
25. Fractured ribs.
28. Compound fracture of tibia and fibula.

Cases under Mr. Davies-Colley.

Job
1. Paraphimosis.
2. ? *Mycosis fungoides.*
3. Ununited fracture of tibia.
4. Spinal caries with sinus.
5. Tuberculous knee. Excised.

Job
6. Tuberculous knee. Excised.
7. Halluces valgi and bunions.
9. Retention ? Prostatic.
10. ? Renal calculus.
11. Secondary malignant glands in neck.
12. Lumbar abscess. Incised.
20. Old excision of knee. ? Locomotor ataxy.
21. Anthrax. Pustule excised.
22. Mastoid abscess. Antrectomy.
25. Bullet in arm.

Lydia
1. Gummatous ulcers on leg.
2. Tuberculous shoulder. Incised.
3. Fractured patella. Splints.
4. Tuberculous hip. Excised.
5. Strangulated umbilical hernia. Kelotomy.
7. Rodent ulcer on forehead.
8. Strangulated femoral hernia. Kelotomy.
11. Carcinoma mammæ.
12. Carcinoma recti. Kraske's excision.
13. Fractured pelvis.
16. Fractured clavicle.
18. Genu valgum.
Cot A. Fractured vertex (compound) and fractured maxilla.
B. Cleft palate and hare lip. Plastic operation.
C. Fractured femur. Vertical suspension.

Cornelius
6. Bullet in hand.
7. Hæmatoma of scalp. ? Fractured base.

Cases under Mr. Lucas.

Lazarus
1. Recurrent sarcoma of crureus. For Coley's fluid.
3. Œsophageal stricture. Gastrostomy.
5. Nasal polypi.
6. Recurrent epithelioma of face. Excised.
16. Mastoid abscess. Antrectomy.
17. Mastoid abscess. Antrectomy.
18. Ankylosed metacarpo-phalangeal joint.
19. Epithelioma of cheek on scar of lupus erythematosus. Excised.
21. Parotid sarcoma. Excised.

Martha
1. Cleft palate. Plastic operation.
2. Carcinoma mammæ. Excised.
3. Tuberculous elbow and other tuberculous lesions.
5. Tuberculous elbow. Excised.
6. Cerebral abscess. Trephined and drained
14. Tuberculous tarsus. Pirogoff.
15. Cystic breast. Excised.
16. Compound fracture of tibia and fibula.
19. Bullet in brain. Extracted.
21. Calculous pyonephrosis. Nephrolithotomy.

MARTHA 22. Hammer toe. Amputated.
Cot D. Fractured femur.
ASTLEY COOPER 8. Compound fracture of tibia and fibula.
15. Fractured patella. Wired.
22. Fractured femur. Hodgen.
24. Fractured femur. Double Bryant.
27. Ruptured intestine. Resection.

CASES UNDER MR. GOLDING-BIRD.

LUKE 1. Irreducible inguinal hernia. Radical cure.
6. Moveable kidney. Nephrorraphy.
13. Stricture with retention.
14. Mastoid abscess. Antrectomy.
16. Sarcoma of neck. Excised.
17. Mastoid abscess. Antrectomy.
18. Epithelioma of hip. Excised.
19. Tuberculous shoulder-joint.
20. Gonorrhœal synovitis of knee.
21. Tuberculous elbow. Excised.
CHARITY 2. Calculous pyonephrosis. Nephrolithotomy.
3. Adenoids.
4. Umbilical hernia. Radical cure.
6. Tuberculous ankle. Syme.
8. Sarcoma of buttock. Excised.
9. Ruptured urethra.
10. Lipoma of buttock. Excised.
11. Pott's fracture.
12. Fractured patella.
13. Ununited fracture of tibia.
14. Sarcoma of femur. Amputation through thigh.
15. Tuberculous glands in neck. Excised.
16. Appendicular sinus.
17. Ranula. Excised.
18. Spinal caries.
19. Tuberculous hip.
Cot B. Tuberculous metatarsus.
ASTLEY COOPER 10. Fractured patella. Wired.
11. Compound tibia and fibula.
32. Fractured ribs and clavicle.
CORNELIUS 9. Fractured femur.
10. Fractured femur.
13. Fractured femur.
20. Pott.

CASES UNDER MR. JACOBSON.

NAAMAN 19. Dislocation of first metacarpo-phalangeal joint. Resection.
21. Chancre with phimosis. Circumcision.
22. Fibromata over olecranon. Excised.
DORCAS 19. Right reducible inguinal hernia.
21. Trigeminal neuralgia. Lingual nerve resected.
22. Congenital talipes varus. Phelp's operation.
Cot D. Rachitic tibiæ.

CASES UNDER MR. SYMONDS.

JOB 13. Stricture. External urethrotomy.
14. Epithelioma of fauces.
16. Sarcoma of tonsil and glands. Excised.
18. Carcinoma laryngis. Tracheotomy.
19. Lympho-sarcoma of fauces with glands involved. Coley's fluid.
LYDIA 19. Cystic breast. Partial excision.
21. ? Epithelioma of tongue. Excised.
RUTH 26. Occlusion of larynx. Post scarlatinal.
35. Nasal polypi. Frontal sinus empyema.
PATIENCE Cot. Necrosis of clavicle.

CASES UNDER MR. LANE (Mr. Fripp acting).

LAZARUS 11. Hæmorrhoids. Whitehead's operation.
13. Cystitis.
MARTHA 10. Tuberculous kidney.
12. Mastoid abscess. Antrectomy.
13. Hydatid of liver. Drained.
Cot C. Talipes equino-varus.

CASES UNDER MR. DUNN.

LUKE 3. Recurrent epitheliomatous glands in neck extending to axilla. Secondary to lip.
4. Tuberculous knee. Excised.
11. Hypertrophied prostate : vasectomy. Right cyst of epididymis. Left hydrocele. Excised.
CHARITY 20. Appendicular abscess. Incised.
Cot D. Nævus on face.
SAMARITAN 9. Acute necrosis of tibia, and suppurative arthritis of knee.
12. Necrosis of mandible after fracture.

Case for Diagnosis.

C. R., a waiter, on June 18th, felt ill, and had pains in the limbs and back, and on the following day felt too unwell to go to work. On the 20th he consulted a doctor, who prescribed some medicine; and on the following day, feeling worse, he again visited his doctor, when he noticed difficulty in moving his left leg. On returning home he took to bed; the pains continued, and on the night of the 25th he was sick several times; on the 26th his doctor sent him up to the hospital as a case of acute peritonitis.

On admission his temperature was 100°; pulse 82, of good tension and regular; he was pale, with sunken eyes, furred tongue, foul breath, and lips and teeth covered with sordes. The abdomen was distended and rigid, with a tympanitic note, except in the lower part where the bladder was felt, as a tense fluctuating tumour extending to within an inch and a half of the umbilicus. The patient stated that he had passed no water for three days, and about two pints of normal urine were drawn off. The liver dulness was abolished. During the examination of the abdomen the patient remarked that he could not feel the examining hand; he also complained of great pain just below the right nipple, and on the left

side at the level of the sixth rib. It was then found that below this level there was complete anæsthesia, and paralysis of the legs, abdominal muscles and lower intercostals, and apparently of the diaphragm, since there was absolutely no movement of the abdomen with respiration. The knee-jerks were completely absent, as were the cremasteric and right plantar reflexes. There was a large bedsore over the right iliac crest behind. There was no boss or tender region over the spinal column. The bowels had not been opened for three days, but after admission there was incontinence of fæces, several motions being passed each day, the last about thirty hours before death. There was retention of urine throughout. Feeding was very difficult, as nutrient enemata were not long enough retained to be of much use, and feeding by the mouth was generally quickly followed by vomiting. The abdominal distension gradually increased, being unrelieved by turpentine and rue enemas, and the passage of a rectal tube, and ultimately became extreme; the patient meanwhile became weaker each day, the voice becoming feeble and harsh. On the night of the 3rd the vomit became stercoraceous. It was not continuous, but there were severe attacks at intervals, and on the morning of the 9th patient died.

Nursing Notes.

A NEW appointment has been created for the nurses, for which strings are needed. The work will be in the kitchen, dining hall and dormitories. [It sounds a pretty large sphere in which to exercise one's energies.] We are not quite sure what name will be given to the holder of this office, but as she works under the supervision of the housekeeper we presume her official name will be assistant housekeeper, though she has been already dubbed "kitchen nurse."

The post will be a particularly valuable one to hold for those nurses who wish to become matrons of cottage hospitals where experience in hospital housekeeping is made an express proviso. Until now Guy's has provided no training for its nurses in this direction. We are not prepared to record the special duties of the kitchen nurse, our ideas, in common with other people, are rather hazy, but we can correct a few of the prevailing notions. For instance, some of the nurses have been heard to say that it was a post they could not undertake, as they never kept house at home and couldn't so much as cook a leg of mutton. To allay the fears of the community at large we may mention that cook alone will keep a protecting eye over the legs of mutton. It is of no use to buy expensive editions of "Mrs. Beeton's Housekeeper for large and small families;" that will be no guide at all, for there is a legend that the meals are ordered from that place so mysterious and far reaching in its authority—the Office. This latter information not thoroughly reliable. We wish to contradict also the report which says that the kitchen nurse will stand every morning at the door of the dining hall to receive orders from those nurses who are not late for breakfast for the menu for the following day. The present nurse had four hundred and sixty-two suggestions concerning meals the first hour of holding office.

We have nothing to say about the Garden Party, it was a great success, and though only those nurses were invited who had left their stripes behind, many stringless ones were seen in the grounds, even at the prize giving. The procession looked very warm. Being composed of such imposing individuals we dare not launch forth into even an admiratory criticism.

Everyone will be glad to hear that a Guy's nurse headed the list of successful candidates in the examination for massage, and additionally so as she was coached by one of our own nurses.

HEAVE a sigh of relief, oh pros! The medical examination is, for most of you, a thing of the past.

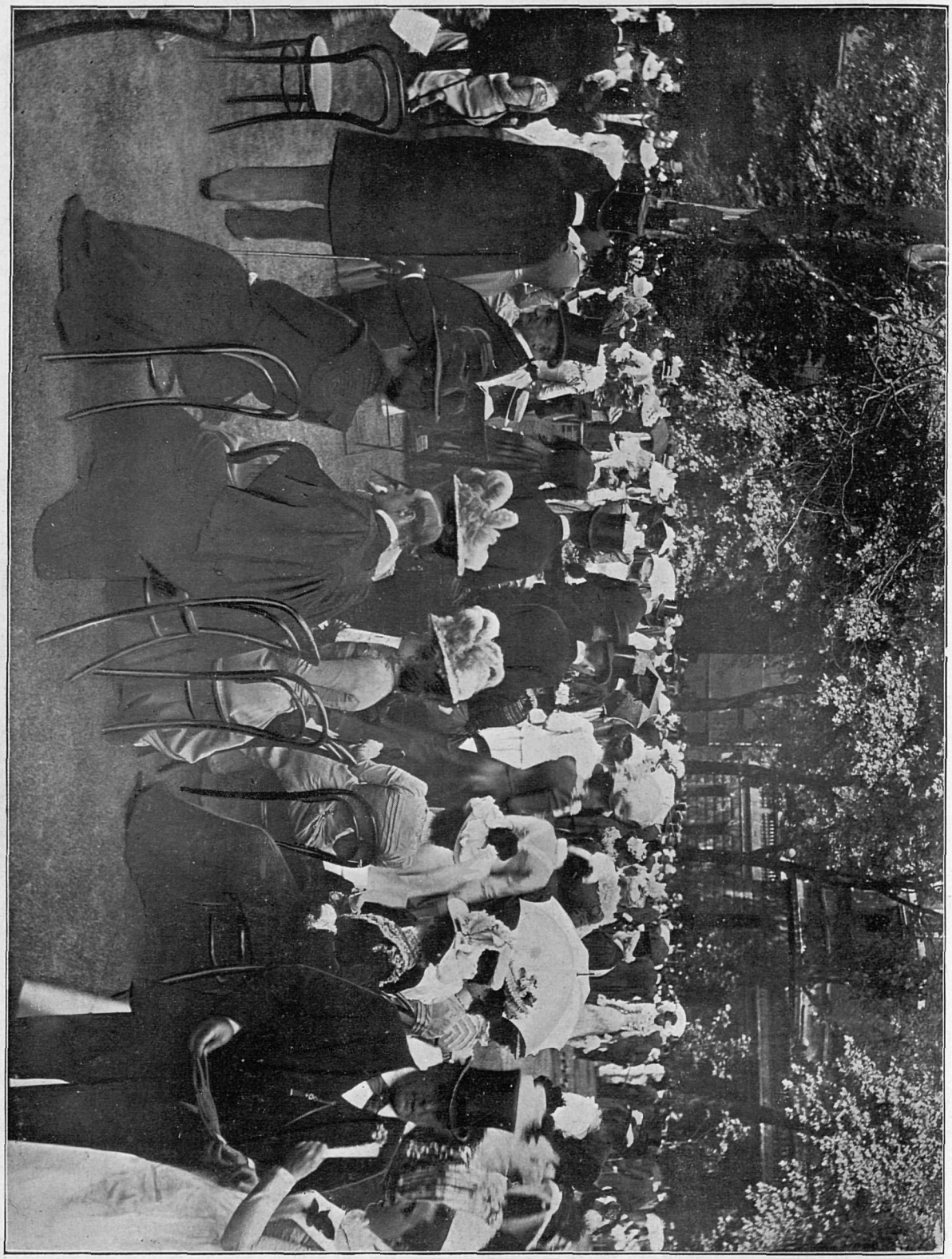
Coming down the medical stairs last week we encountered an eiderdown, a frying pan, a bundle of books, a teapot and a blacking-brush. They were all held in a tight embrace by a nurse (we are none of us pro.'s in this column). I then remembered that it was the quarterly change for the pro.'s, and that this unfortunate one was changing from a night to a day cubicle. No one can realize what this means till they have tramped from the top of medical to the top of surgical with all their worldly belongings. The Transit of Venus was nothing to it.

"L'INCONNUE."

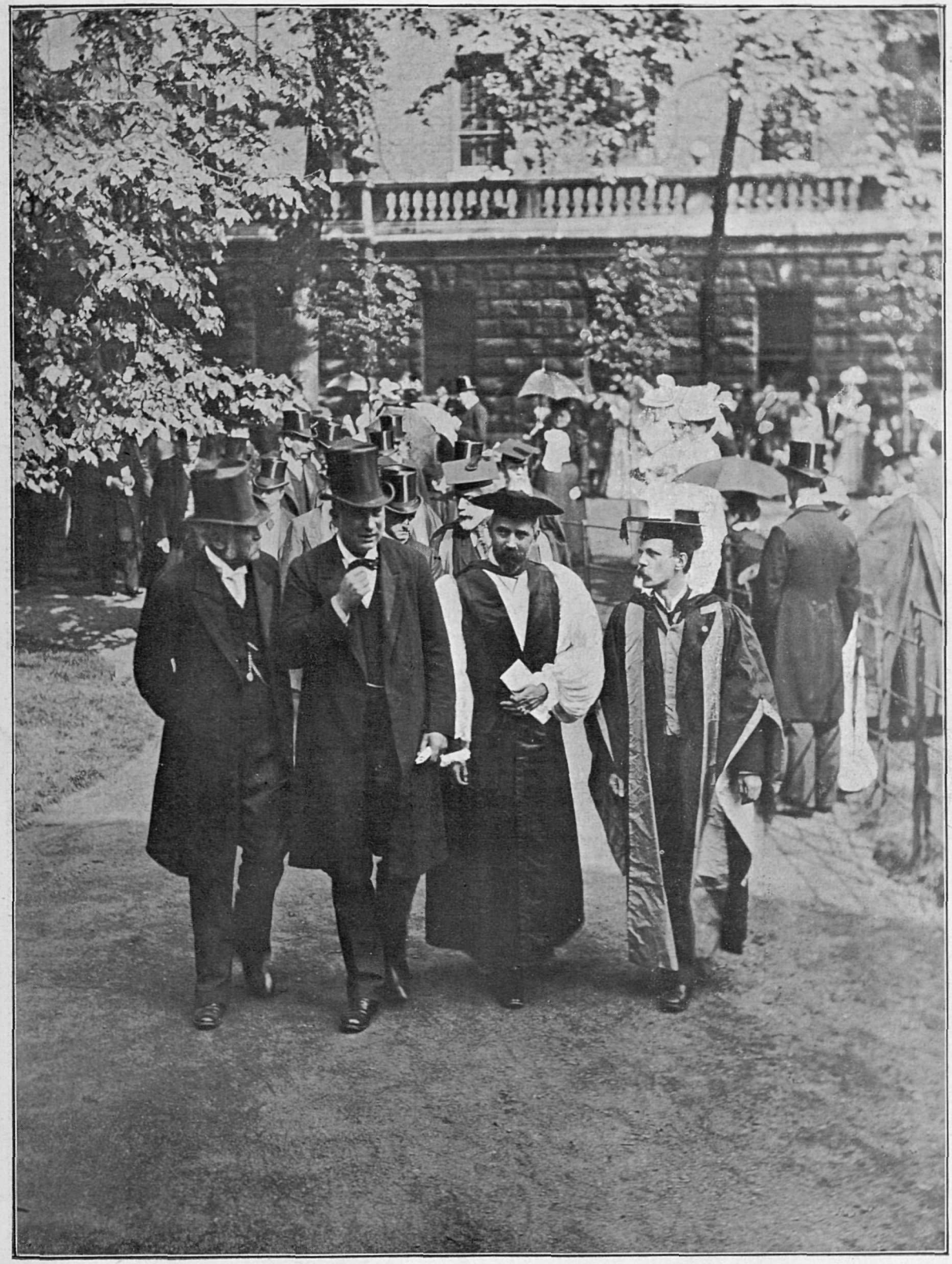
Guy's Hospital Debating Society.

THE Annual Dinner of the above Society will be held in the College Library, to-night, at 7 p.m. J. H. Bryant, Esq., M.D., in the chair. Price of Dinner, 2s. Morning dress.

F. SHUFFLEBOTHAM, } Hon.
J. M. BRYDONE, } Secs.



GARDEN PARTY, JULY 7th, 1899. In the Park.



Mr. GORDON. *Mr. H. COSMO BONSOR.* *THE BISHOP OF SOUTHWARK.* *Dr. SHAW.*

PRIZE DISTRIBUTION, JULY 7th, 1899. **Leading the way to the Theatre.**

Passim.

Prize Day last Friday week proved highly successful from every point of view. Though not visited this year by Royalty or high political functionary, Guy's in no way modified the brilliancy of its costume for the occasion, and being at the same time favoured with a fine day among fine days, every thing combined to make a colour picture of which, alas, our photos can give but little idea to those who were unfortunate enough to be away.

The keynote of Mr. Gordon's excellent speech was "Research," a subject in which we all know he is deeply interested, and which he is doing his utmost to promote at this hospital. And rightly too. As he truly remarked, there is no reason to believe that discoveries will ever cease, and why should not Guy's be the birthplace of some of the greatest of them? Of course this question of medical research is not exactly one which appeals to the general public, but it is one which certainly ought to appeal to all members of our profession, however humble; for on the discoveries of modern times is based all our knowledge and treatment of all infectious diseases, and of many other affections as well. Modern surgery, too, is entirely built upon the discoveries and work of Koch, Pasteur, Lister, and others, and who knows what research may have in store for us in the future.

Granted, then, that medical progress is to a very great extent dependent on medical research, it is clearly our duty to press forward the claims of our Medical School as a centre for the investigation of the problems so constantly met with clinically, and which at present so completely baffle all attempts at their solution. Since Mr. Balfour's appeal, twelve months ago, something under £7,000 have been received towards the requirements of the Medical School. The requirements, however, as set forth in the Hospital Report for 1898, amount to something like £100,000, and towards this our Treasurer will gratefully receive any donations or legacies. We would refer all to pages 24 to 26 of the Report, where the claims of our school will be found set forth by an abler pen than ours.

Not the least interesting of the announcements made on Prize Day was the one which told us that Dr. Pye-Smith and Dr. Goodhart had been appointed on the Consulting Staff of the Hospital. Although everyone had anticipated it, yet there will be none the less eagerness to congratulate them on the distinction, for no one deserves the honour better.

Dr. Pye-Smith has accordingly resigned the office of lecturer on Medicine, and, as previously announced, Dr. Hale White has been appointed to fill the vacancy, and in consequence of the rule which debars one man from holding two lectureships at the same time, he accordingly hands over the Materia Medica seat to Dr. Perry.

As will be seen from the account published on another page, Guy's failed signally in the endeavour to recapture the Athletic Shield, which goes back to St. Bartholomew's again, after a four years' lodging at St. Mary's. It is difficult to account for, but it certainly is a fact that athletic sports in general, and the inter-hospital ones in particular, are quite the reverse of popular at the present time. Just imagine. Only two men from Guy's, besides the President and competitors, on the ground! And yet, six years ago, there was a crowd four or five deep all round. What is it coming to?

It cannot be said that the sport was poor for the performances in the half, hurdles, and long jump, were far above the average, Leggatt's jump of 23ft. 4½in. being quite the feature of the afternoon. The absence of any band certainly detracts from the pleasures of a meeting of this character; but with such poor support, the committee cannot see their way to go to any unnecessary expense, or take any risk of a deficit.

The defeat of the Hospital in the final of the Inter-Hospital Water Polo Competition, though somewhat expected, certainly brought no dishonour with it. On the contrary, our men are to be congratulated on the excellent fight they made against their more skilful opponents. The latter, by the way, certainly did not enhance their reputation by their victory, but rather discounted it by frequently indulging in unfair tactics. It was a great pity, too, that one of the players was allowed such free use of his tongue in the presence of so many ladies.

Yet another beating. This time it is the Shooting Bowl, which after a brief year's stay, bid us a sad farewell last Thursday. Our men

did well, but not well enough, and in the end had to put up with third place, forty-one points behind the winners. Sic transit gloria.

We hope to publish in our next issue a short account of Dr. Fawcett's wedding, which takes place to-day at Hampstead. All will join with us in wishing him a most happy and prosperous future. Few men have done more to promote the welfare of the men at this hospital than has John Fawcett, and as Secretary of the Students' Club, only those in the know have any idea of the amount of work done by him, and time spent in the discharge of the duties of that unenviable post.

We regret to have to record the terribly sudden death of Henry Naunton Davies, an old Guy's man who qualified in 1854, and who has practised practically ever since in the Rhondda Valley, South Wales. An Alderman and County Councillor, as well as Justice of the Peace, he was very well known and respected at Porth, and throughout the neighbouring valleys, and his sudden death by cerebral hæmorrhage, while on a well-deserved holiday, leaves a void which will be hard to fill.

On June 14th, last, H. Evelyn Crook, a former editor of this Gazette, was called to the Bar.

Guy's may well be ashamed of herself. Four years ago she held the athletic shield; now she sends in barely half a dozen men and secures one first and one second place. With the exception of Roper and Nash not one of the men was really fit; and several men, who, with training, could at least have made a respectable show, fought shy of the durance vile, and preferred the softer amenities of cricket, tennis, or loafing. The sporting spirit seems dead in Guy's. Whether it is the privacy of the meeting at Honor Oak Park, and the abolition of a strangers' race, or whether it is that Guy's men haven't the power or the pluck to make a fight for the shield, it is at least certain that Sime can't win the shield for us without any backing, and that as things are we shan't win that shield for the next four years. If you are a chronic, you had better be an athlete than spend your days in Peall's billiard-rooms.

Dr. Robert Howard, Mr. Lucas's house-surgeon last year, who left us in February to take up an appointment as Medical Officer to the Universities' Mission in Central Africa, has arrived at Lake Nyassa after an eight weeks' journey from the coast. He appears to be perfectly happy opening abscesses and hunting jiggers in the natives' feet; and intends to move to his final destination, Kota-Kota, on the Western shore of the lake, in a few weeks. There he will not be far from Dr. Patrick Higgins and our other Central African representatives.

Nursing News.

It is satisfactory this week to be able at last to report the results of the recent examinations. On June 19th and 20th, the "Institute of Trained Masseuses," held an examination, and Senior Probationer Archdale (our only candidate) took first place. (Instructress, Nurse Villes.) On July 3rd, 10th, and 11th, the Obstetrical Society held their examination for the much coveted L.O.S. Six candidates from Guy's entered, and we have much pleasure in saying that they were all successful. The candidates were:—Nurse Chester, Nurse Harbottle, Nurse Tippetts (Instructress, Sister Victoria); and Nurse O'Neill, Nurse Price, Nurse Tubbs, F. (Instructress, Nurse Fricker.)

The medical examination for Probationers and Lady Pupils was held on Thursday, June 29th. There were eighty-five candidates of whom eighty were successful. The following is the list of successful candidates:—Adams, Akers, Andrews, Baker, Baynes-Read, Beales, Beard, Bell, Bible, Blayney, Blower, Clark, Collins, B., Cooper, Copley, Corder, Crampton, Creasey, Davis, A., Davison, Dawson, Evans, A., Evans, E., Faulkner, Ferrier, Field, Gatward, Gibbins, Goodwyn, Graham, Harradaine, Harvey, Hayward, E., Hayward, S., Heygate, Hickman, Hindley, Houston, Howlett, Hyde, Holman, Johnson, Jones, E., Leveaux, D., Leveaux, V., Lindon, Lord, Lowe, Lowthin, Lyon, Mackenzie, Macnaughton, Manners, Minshall, Mousell, Nash, Palmer, Peglar, Pitman, Popple, Rainbow, Ramsey, Reeve, H., Risdon, Roberts, Schofield, Sister Edith Emily, Smart, Spalding, Stanyon, Swadling, Thompson, A. C., Thompson, E., Tilley, Tompkins, Vivian, Whiteman, Wallis, Whittingham, Wood, V. Probationers Minshall, Lyon, and Howlett, took first, second, and third places.

On July 1st, Senior Probationer A. Taylor was appointed Head Nurse in Out-patients.

On July 3rd, Senior Probationer Ransford was promoted to be a Head Nurse, and was appointed Junior Dormitory Mistress and Housekeeper, for a term of at least three months.

On July 11th, Nurse Candy was appointed Head Nurse in Martha Ward.

Nurse Florence Hughes, who gained her three years' certificate in June, 1897, has been appointed Matron of the Emsworth Cottage Hospital, and enters on her duties on August 12th.

Nurse Kate Oyler, who gained her three years' certificate in October, 1898, has been appointed Sister of a Women's Medical Ward at the National Hospital for the Paralysed and Epileptic, Queen's Square, Bloomsbury, and enters on her duties on Tuesday next, July 18th.

Prize Day, 1899.

ROBERT GORDON, ESQ., performed the pleasing duty, this year, of distributing the prizes to the successful students. The ceremony took place on Friday afternoon, July 7th, in the new Anatomical Theatre, and was witnessed by a large and distinguished company, comprising many well-known supporters and friends of the hospital. At 3.30, H. Cosmo O. Bonsor, Esq. (Treasurer), took the chair, and was supported by the following: Hon. Sir Chas. Fremantle, Bart., Sir. Frederick Wills, Bart., M. Trevelyan Martin, Sir W. Cameron Gull, Bart., M.P., J. E. Gladstone, Robert Gordon, C. R. Gurney Hoare, H. H. Raphael, Robert Barclay, General Clive, J. H. Benyon, W. Seton Karr, Sir Samuel Wilks, Bart., Lord Bellew, Lord Bishop of Southwark, Alderman and Sheriff Alliston, Col. and Sheriff Clifford Probyn, Master of the Grocers' Company, Prime Warden of the Fishmongers' Company, Master of the Curriers' Company, Ven. Archdeacon Sinclair, Sir James Blyth, Warden of St. Bart's. Hospital, Chancellor of St. Saviour's Collegiate Church, W. G. Rushbrooke, Esq., LL.D., Headmaster of St. Olave's Grammar School, Rev. Dr. W. McLeod, and the majority of the Staff.

THE CHAIRMAN: Ladies and gentlemen—I think we may always congratulate ourselves that we are not on the South-Eastern; we are very punctual. (Laughter.) I have, in the first instance, to ask our distinguished governor, Mr. Gordon, who, as you are well aware, has been a contributor to the funds, to give away the prizes, and I will ask the Dean (Dr. Shaw) to be good enough to read the names of the successful students.

L. E. SHAW, ESQ., M.D., then read the list of Entrance Scholars, Prizemen and Medallists, and each recipient, on being handed his reward by Mr. Gordon, was heartily applauded by the spectators.

The following are a list of Medallists and Prizemen:—

OPEN SCHOLARSHIPS IN ARTS.—Robert Fenton Macdonald, Bancroft School, Woodford Wells, £100; George Hamilton, Aske's School, Hatcham, £50. DENTAL STUDENTS.—John Walker Walton, Folkestone Grammar School, £30.

OPEN SCHOLARSHIPS IN SCIENCE.—Edwin Henry Britton Milsom, Christchurch, New Zealand, £150; Frederick Rogerson, Guy's Hospital, and Neville Ivens Spriggs, equal £30 each; Herbert Douglas Smart, Guy's Hospital, Certificate; Henry Swarbrick Brown, Guy's Hospital, Certificate.

SCHOLARSHIP FOR UNIVERSITY STUDENTS.—Herbert Stanley French, Christ Church, Oxford, £50; Ecroyde Ihler Claxton, King's College, Cambridge, Certificate.

JUNIOR PROFICIENCY PRIZES.—Carrick Hey Robertson, £20; Joseph Tremayne Hicks, £15; Albert Ernest Hardman Pakes and Alfred Herbert Edwin Hall, equal £5 each; Percival Pasley Cole, Certificate.

THE MICHAEL HARRIS PRIZE FOR ANATOMY.—Carrick Hey Robertson, Prize £10; Alfred Herbert Edwin Wall, Certificate; William Gibson Parker, Certificate; Harold Thornbury Palmer, Certificate.

THE WOOLDRIDGE MEMORIAL PRIZE FOR PHYSIOLOGY.—Joseph Tremayne Hicks and Albert Ernest Hardman Pakes, equal £5 each; Percival Pasley Cole, Certificate; Ellis Gordon Goldie, Certificate.

THE HILTON PRIZE FOR DISSECTION. [1898.]—Claude Tessier, £5.

THE ARTHUR DURHAM PRIZES FOR DISSECTIONS.—FIRST YEAR'S STUDENTS.—Alexander Moxen Webber, Prize, £5; Neville Ivens Spriggs, Certificate; Charles Derwent Pye-Smith, Certificate. SENIOR STUDENTS.—Carrick Hey Robertson and Alfred Herbert Edwin Wall, equal £7 10s. each.

DENTAL PRIZES.—SECOND YEAR'S STUDENTS, 1898.—Percival Sidney Campkin, Prize, £15; John Stewart Farnfield and Ernest Noel Mason, equal Certificates. FIRST YEAR'S STUDENTS.—Charles Sculthorpe Morris, Prize, £10; John Bennett, Certificate.

PRACTICAL DENTISTRY PRIZE.—Charles Sculthorpe Morris, Prize, £10; John Bennett, Certificate.

SENIOR PROFICIENCY PRIZES.—Caleb Thomas Hilton, £20; Ernest Blair Dowsett, £15; George Norman Meachen, £10; Alfred Reid, Certificate.

THE RICHARD BREDIN PRIZE FOR CLINICAL STUDY.—Russell Henry Jocelyn Swan, £25.

THE GOLDING-BIRD GOLD MEDAL AND SCHOLARSHIP FOR SANITARY SCIENCE.—Stanley Copley, £20; Claude Martin Vernon, Certificate; Harry James Spon, Certificate.

THE TREASURER'S GOLD MEDAL FOR CLINICAL MEDICINE.—Graham Scales Simpson.

THE TREASURER'S GOLD MEDAL FOR CLINICAL SURGERY.—Caleb Thomas Hilton.

THE CHAIRMAN: I will now ask Mr. Gordon to say a few words to those gentlemen who have received prizes.

ROBERT GORDON, ESQ.: Ladies and gentlemen.—The Treasurer of this Institution is so accustomed to have his own way in everything inside these walls that when, without my consent, he nominated me to this pleasing duty, I felt it had to be done. (Laughter.) The nervousness natural to being called upon for the first time to take part in such a function is not diminished by the remembrance that a year ago the Hospital was honoured by having the prizes presented by Mr. Arthur Balfour, whose eloquent words, I feel sure, still linger in the memories of those who were present on that occasion. The appeal which he made for scientific research has, unfortunately, not been responded to to the extent that we hoped for. Money, in no stinted measure, in the form of subscriptions and legacies, has flowed into the treasury of the hospital, but not in such way as would warrant the Governors in making special appropriation for scientific research. The more urgent needs of the hospital, in the way of new buildings or repairs which are always required, have absorbed all the money which has come in, large as the amount has been, and we still ask for more. Now it appears to me that we of the present day, certainly those of the younger generation, do not fully realise what scientific research has done for us in the past. In the early years of the present century

there issued from the press that monster publication, Rees's Encyclopædia, comprising some forty volumes, which occupied towards the knowledge of that day very much the same position as the Encyclopædia Britannica does to that of the present time. In those volumes you may search in vain for any mention of anæsthetics, antiseptics, bacteriology, bacilli, microbes, telephones, photographs, phonographs, and a great many other things which have become so much a part of our every-day life that we can scarcely imagine how the world ever got along without them. None of these discoveries, important as they are, were the result of accident, but of thoughtful, long, patient investigation, in many cases extending over years. We are indebted to Morton and Simpson for the introduction of anæsthetics, which certainly have conferred one of the greatest boons upon suffering humanity. The researches of Pasteur and Koch in the direction of bacteriology have accomplished wonders, making us acquainted with many of the mysteries of human life. In that book of which I spoke, electricity was dealt with rather extensively, but it simply gave the very simplest elements of electricity, illustrated by experiments which might interest school-boys of the present day. As to telegraphs, the few pages devoted to the subject are simply occupied by a description of the various methods—semaphores, flags, lights, etc.—which were the only means then available for the communication of intelligence to places at a distance. The researches of Faraday in the direction of electricity were followed by those of Lord Kelvin, Wheatstone, Morse and others, and more recently by the discoveries of such men as Edison, and have resulted in giving to us not only the phonograph, telephone and the electric telegraph, but submarine cables, by means of which intelligence is conveyed to us day by day, from all parts of the world, so that when we open our newspaper in the morning we expect to acquaint ourselves with what has been going on in all quarters of the globe, though sometimes the intelligence is not quite authentic. (Laughter.) Now, it is only some two or three years ago that the little German city of Wurzburg woke up suddenly to find itself made famous through the discovery by one of the professors in its University—Professor Röntgen, of those marvellous rays which now bear his name, and which, supplementing the anæsthetics of Simpson and the antiseptic treatment of Lister, which latter is second only in importance to the discovery of anæsthetics, enable the surgeons of the present day fearlessly and confidently to undertake operations which before were absolutely impossible. Now, it is not to be supposed that nothing remains to be discovered, and that we of this present day have attained to the end of knowledge. It is possible—nay, probable—that the coming century may be marked by just as marvellous discoveries as those which have marked the century now drawing to a close. To lead to such discoveries, however, it is absolutely necessary that the means should be provided. You cannot have research without instruments, and apparatus, and materials, and, above all, leisure. It is a long, continuous process, and students must be provided with those necessary things before much can be expected from them. Now, it will be a proud day for Guy's when we wake up some day to find that some discovery as remarkable, it may be, as that of Professor Röntgen, has been made by a member or graduate of Guy's, and to enable them to do this we must, as I have said, provide them with the necessary materials. When the distribution of prizes takes place next year, I hope that, whoever may have the pleasant honour of presenting them, may be able to announce that the reproach now resting upon us of not having responded to the appeal of Mr. Balfour no longer exists. I should now like to say a few words to the students, not on behalf of the Staff and School Committee, but simply as a member of that committee. I should like to heartily congratulate those who have carried off the prizes this day. Some of you having completed your studies here, are probably now about to enter upon the actual practice of your profession, one of the most honorable that there is, and one which, above all others, I think, gives an opportunity of doing good. Like all other professions it is exposed to the charge of being rather overcrowded, but as was said to the young lawyer who was complaining of that state of affairs in his profession, "there is always room at the top." Now it cannot be expected, of course, that everybody will get to the top, because there is only one top, though there may be different branches of it. But no student entering upon this profession can afford to remain at the bottom; he must determine to mount at least a few rounds in the ladder, and those students who to-day have carried off the different prizes have already taken one or two steps in that direction. It is a good augury of their future success that they should have succeeded in carrying off these prizes against great competition, I have no doubt. Of course we should like you all to enter, as soon as possible, upon a lucrative professsion, but a lucrative profession is not everything. It may be, and probably will be, the lot of some of those who graduate from this place not to attain to that perhaps for a long time. It may be your lot to practise your profession in some isolated place, in some circumscribed locality, outside of which your name may not be known, but inside of which you will enjoy the respect and, it may be, the love of everyone in it. Now, Ian Maclaren, in his beautiful story of "A Doctor of the Old School," has described a man occupying such a condition as that. In the preface of a later edition of his work he says he had been many times asked if he had ever known a man so utterly forgetful of self, and so utterly Christian in his spirit, as the hero of his story, to which he was able to reply, "Not one, but *many*, both in Scotland and the South Country." He says further that he had been privileged to receive many letters from medical men, probably practising their profession under difficulties, possibly against small means and little apparent appreciation of their efforts, stating that from the perusal of the story they had derived fresh courage for their work.

He adds, "It is surely more honour than a new writer could ever have dreamed to receive the approbation of a profession whose charity puts us all to shame." Remember that we look to you to sustain the honour of Guy's. There are but few parts of the world where our graduates have not found a foothold, and worthily maintained the high reputation of their "Alma Mater." You carry with you the sincere good wishes of all who are associated in the government of the hospital, and to each and all who go out from our schools we extend a hearty God speed. Well, you are going forth to maintain the character and high-standing of Guy's. In all parts of the world the graduates from this school are doing their work, and we hope maintaining worthily the reputation of their own Alma Mater. You go forth bearing with you the good wishes of every member of the Governing Body and Staff; to each one who goes out we wish a hearty God speed. (Applause.)

H. COSMO BONSOR, ESQ., M.P.: Ladies and gentlemen, in the very eloquent speech which we have just listened to, I am bound to say that Mr. Gordon only made one slip; he alluded to the treasurer of this hospital as being an autocrat in this building. (Laughter.) I can assure you that if the treasurer was such, he would have pleaded for some of the worthy and eloquent people around him to propose the vote of thanks which it is my duty to give to our distinguished friend. But your dean, the worthy dean of the school, makes out the programme, gives his orders, and we all have to obey. (Laughter.) Well, ladies and gentlemen, I think he has done the right thing in insisting that the treasurer shall move the vote of thanks to the gentleman who has been good enough to come down and give away the prizes, because it gives the treasurer an opportunity of saying a few words on those things which have proved interesting to Guy's Hospital during the last twelve months. It is just twelve months since Mr. Arthur Balfour gave away the prizes, and the eloquent speech he then made, induced my friend Mr. Gordon to send a handsome cheque towards medical research. (Applause.) That liberality was almost immediately followed by that of another of the governors, Sir Frederick Wills, who sent a handsome donation of £5,000 towards the school, with the wish that the money should be connected particularly with the library of Guy's Hospital. (Applause.) Consequently, ladies and gentlemen, that speech by Mr. Balfour brought forth fruit, and I have no doubt that the speech we have listened to to-day will bring forth even more. But when I turn to other spheres of interest, I must not for one moment forget that we have lost by death a considerable number of our governors during the last twelve months. I need not mention all their names, but one I must mention, the late Mr. Raphael, who was so liberal in his donation of £20,000 with which to found a home for our nurses in memory of his late wife. Unfortunately, he did not live to see that work even commenced. Ladies and gentlemen, it is a great sorrow to all of us that he has been taken away. However, I am thankful to think that some of his relatives have joined our court, and will see that work through. With regard to the medical staff, I am reminded that time rolls on, and even some of our young friends have begun to grow old. Dr. Pye-Smith, I regret to say, is approaching the time when under the compulsory rules of this hospital he has to retire from the active work, but I can only assure you, ladies and gentlemen, that it gives to the governors of this hospital the greatest pleasure to have elected Dr. Pye-Smith on the consulting staff (applause), so that so soon as he retires from active work, there should not be a minute lost in his connection with that hospital which he has served so well, both inside the walls of the hospital, and in the school to which he is so deeply attached. At the same time the governors had the greatest pleasure in adding Dr. Goodhart's name to the consulting staff of the hospital. It is by means like this that the governors hope to continue to keep together not only those who are at present passing through the school, but those who have passed through the school, and done service for the hospital, so that Guy's School and Guy's Hospital may long continue one united family. (Cheers.) Now, while we are losing Dr. Pye-Smith from our active staff, it naturally makes room for promotion, and accordingly a gentleman not altogether unknown to you takes a step up, Dr. E. C. Perry; and we have to-day appointed a friend of nearly all of you, Dr. Fawcett, as an assistant physician. Ladies and gentlemen, I could continue my speech for some time on the interesting topics of Guy's Hospital, but I wish to recall to your minds the reason why I rose. I rose to move a most cordial vote of thanks to Mr. Gordon for the service he has rendered to the School already, and for his eloquent speech, and to express the hope that he may long live to see his work absolutely completed. Ladies and gentlemen, it is only natural that I should call upon Dr. Pye-Smith, our Senior Physician, to second that vote of thanks, and Dr. Stevenson, our Senior Lecturer in the School, to support it. I beg to move the vote of thanks. (Applause.)

P. H. PYE-SMITH, ESQ., M.D., F.R.S.: Ladies and gentlemen, I have much pleasure in seconding the vote of thanks, and I am sure I express the feelings of everyone here when I say that more thoughtful and, I believe, more fruitful words we could not have listened to, for when he spoke of the "fruitless" eloquence of Mr. Balfour last year I was reminded of what the Lord Bishop of Southwark will, I think, admit to be the best test of the eloquence of a sermon, and that is, its effect. (Laughter.) I recollect once hearing a sermon of the most eloquent preacher I ever listened to, the late Dr. Magee, Archbishop of York. He was preaching then for a charity, and after his sermon was ended large sums of money were poured into the dishes taken round to receive them; but what struck me most of all was that in the gallery-pew where I was sitting there was a young man and woman, belonging to the very humble class of cockney citizens, who had been listening to the sermon and who when the plate came round, emptied, he his pockets and she her purse, and poured all the silver and copper that they had into the charger, with the tears

running down their cheeks. I thought that was fruit which any preacher might be proud of. And it is gratifying to know that the speech of Mr. Balfour has not been fruitless. First of all, in our scientific studies we had the help of Sir Cameron Gull who founded a Studentship for his father whose memory is still with us; and those who have held that Studentship have, I venture to say, amply justified the wisdom of that foundation. Then we had the munificent gift of Sir Frederick Wills, and now we have had the gift of Mr. Gordon, and I am quite sure that that kind of liberality has a tendency to breed, and that such donations put side by side will soon have a large and increasing flock. (Laughter.) We thank Mr. Gordon for his speech to-day, and I may be allowed to thank our friend, the Treasurer, for the very kind way in which he has spoken of myself. I feel it a great honour and a great privilege that the Governors have put me in that position which is occupied by our old friends Sir Samuel Wilks and Dr. Pavy, and I feel that as we can no longer be occupying the position of a working member of this noble Hospital and School, the next best thing is to be a nominal member, and to taste, as it were, the honours of apotheosis, before one has quite finished one's earthly career. I can only say that so long as life continues I shall feel the deepest attachment, which you all do who are connected with this place, to Guy's and all that pertains to it. It is nearly forty years since I came here, and I have been connected with the hospital ever since in various positions, and in none have I found more enjoyment than in the first appointment I had here as demonstrator. Those of my young friends and former pupils who are now with their feet on the first round of the ladder, I congratulate on their first appointment, and I trust they may prove eminently successful in their respective positions. As we look back over the long list of eminent men who have been connected with us, we think of those to whom we owe so much. We think of our Treasurers. There was Mr. Harrison who for fifty years held that position. We have had Mr. Bonsor called an autocrat, but I venture to think he has no idea of what autocracy means. (Laughter.) From what we hear of Mr. Harrison, there was not a pint of beer brewed, a loaf baked, a student admitted, a patient let in or out, but he did not know of it; and it has been said of him that at a meeting of Governors, when a humble young nobleman, who was lately appointed, asked if he might say a few words, the Treasurer remarked, "Say a few words, sir? How can I let you speak? I know what you are going to say!" (Laughter.) Then there was Mr. Thomas Turner whose memory will always be cherished by the governors and others who knew him. Then there was the late Lord Lushington, who was treasurer for twenty years, and who, I may remind my fellow physicians and surgeons, at the last staff meeting, when we invited him to be our guest at his leaving, made a speech, that I am sure, conquered our hearts. And then we have Mr. Bonsor, who, were I not beside him, I should say was equal to the greatest Treasurer up to this time, both in mental ability and in stature. (Laughter.) We also remember the great medical officers who have adorned this place. I need not speak of their names; they are familiar to us all. All I would say is that, looking back upon them, they seem greater than they themselves had any notion of. I have heard Sir Samuel Wilks say that when he had to lecture on medicine, he used to stand in the place where Addison lectured, and he assured me he was proud of it. Last, but not least, the success of our great Medical School has been due not only to the treasurers, not only to the great men who have adorned our annals and made our school illustrious throughout the world, but also to the students, and I have known them now for very many years. I may, perhaps, be allowed to say that I am quite sure the prosperity of our school here has been chiefly due to the students, and especially to the senior men, to those holding high appointments, and others who have distinguished themselves at the universities, and who, I am sure, have given a tone and character to our men which has improved steadily, which has become deeper and better every year that I have been connected with the place, and which, I believe, is now at a height that has never before been attained in this school. May that long continue; may we have treasurers as wise as the one who now presides over us; may we have men who emulate the glories of our long list of great names in the past; and may we have generation after generation of young and generous students, active in all that is noble and manly in mental and bodily qualities, and gentle and sympathetic in all their relations with poor, suffering humanity, and for whom we pray that their prosperity may be continuous. (Applause.)

DR. T. STEVENSON: Mr. Chairman, ladies and gentlemen, I have been asked on behalf of the teachers and lecturers of the medical school to support this vote of thanks to Mr. Gordon for his kindness in coming here and giving away the prizes, and giving us also that most interesting and instructive speech. You will not expect me, after the eloquent words of my old friend and contemporary, Dr. Pye-Smith, to say much, but I do desire to thank Mr. Gordon especially for the very kind way in which he has spoken to our students. Some think that a distribution of prizes is altogether a mistake. I myself am not of that opinion, for I am quite sure that those who have gained even the smallest success at these examinations will hereafter feel grateful for such opportunities as have been afforded them for so doing. I know, speaking personally, that when I entered this hospital I competed for a scholarship or prize and I only gained a very moderate certificate, but that stimulated me to further exertions, and had it not been that this small piece of paper was given me, probably I should never have attained to the proud position which I now occupy. I thank Mr. Gordon on behalf of the medical school for the kind way in which he has come among us on this occasion. (Applause.)

The vote of thanks was carried by acclamation.

Robert Gordon, Esq.: Ladies and gentlemen, I thank you very cordially for this expression of kindness towards myself. I would like to add just one word, and that is, to recommend the students, if they have not already done so, to read "The Doctor of the Old School," in which they will find a most delightful description of the life of a man who devoted himself simply to doing good, regardless of the small amount of emolument attaching to his position. (Applause.)

The interesting proceedings then terminated.

The United Guyite Club of 1868.

The thirtieth annual dinner of the United Guyite Club, which was founded in 1868, was held on June 28th, at the Restaurant Frascati, when eighteen members sat down to a very enjoyable repast. Sir George Pilkington, M.P., the recently elected member for Southport, who will be better remembered as George Coombe of his student days, took the chair. In the course of the evening he sang the following very original students' song, which he first sang after the particular examination alluded to, at a hotel which need not be indicated.

PRESIDENT'S SONG.

Air—"King of the Cannibal Islands."

Come, fill your pipes and glasses again,
Like true philosophical medical men,
And I'll give you a bit of a song if I can
Of the Royal College of Surgeons.
The winter's term will soon be done
For every 2nd year's mother's son,
When some will get through and some will get spun
At the Royal College of Surgeons.

Chorus.

So hurrah for the men who get safely through.
And hurrah for the plucked, for there must be a few,
And hurrah for the good old examiners too
At the Royal College of Surgeons.

Now, anything mentioned in Kirke or in Ellis,
From the Plantar Arch to the Circle of Willis,
From the Occiput down to the Tendo Achillis,
They may ask at the College of Surgeons.
They've bones and ligaments, all the lot,
They've pickles in many a jar and a pot,
In fact they've got the devil knows what
At the Royal College of Surgeons.

Chorus.

From the sole of the foot to the palm of the hand,
The structure of every mortal gland,
And a thousand things more you must understand
If you go to the College of Surgeons.
The external ring, what's above and below it,
The Vas Deferens, too, you may have to show it,
It'll make a *vast difference* if you don't know it
At the Royal College of Surgeons.

Chorus.

So stick to the knife and the three-legged stool
And then this jolly old medical school
Wont send up a single April fool
To the Royal College of Surgeons.
We'll stick to our books, neither funk nor shirk,
And if they would pluck us on Ellis or Kirke
We'll give the old beggars a stiff bit of work
At the Royal College of Surgeons.

Chorus.

Then let the examiners do their worst
When we go up to pass our "first," *
If we get spun why they'll get cursed
At the Royal College of Surgeons.
We'll stick to our books and grind and cram,
And make short work of their blessed exam.,
And then we shant one of us care a ———
For the Royal College of Surgeons.

Chorus.

In Lighter Vein.

Prize Day of 1899 was an undoubted success. This is the unofficial corner of the Gazette, so you may take that statement as true. The success, though in part due to the state of the weather and the excellence of the band, was mainly attributable to the presence of the celebrated Mr. Gordon, whose family have been so long known to fame as the gallant Gordons.

I had always heard Mr. Gordon referred to as Chinese Gordon, and was a little disappointed to find that he wore no pigtail; but as I have noticed that he dresses his boys in kilts, I presume his tastes are cosmopolitan as regards costume.

The press turned up in force, and a lady journalist represented "the largest circulation." I surmise that with the charming inconsistency of her sex, she omitted to send in her copy, for there was no mention of the function in the paper she adorns. Perhaps the description of the dresses baffled her.

The *Pall Mall Gazette* gave an excellent notice, headed "Guy's Garden Party." This must have been a printer's error. They meant "Guy's Gordon Party."

Take notice that the Debating Society's Dinner takes place to-night. Dr. Bryant will take the chair, and there is every prospect of an amusing evening.

* The 1st Exam. of that time corresponds to the 2nd Conjoint now.

A month ago I made some remarks about the Guy's colours. Now everybody is going about offering those remarks as original observations. Well, I don't mind a bit, but with all the talk we don't get any further. Surely the Students' Club Committee, or the Blues Committee can do something in the matter. As we stand at present it is impossible to tell whether a man is a Blue or a Dentist.

A hospital staff in some out-of-the-way spot has gone on strike. Now just imagine that sort of thing here. I could sketch you out a nice little Guy's strike, but I'm not going to. Still there is no harm in your figuring it out for yourselves, and you may, if you please, picture to yourselves Messrs. A. and B. and Dr. C. as pickets in St. Thomas's Street, and you may imagine Mr. X. calling Dr. Z. a hæmophilic blackleg and pelting him with porringers and things, as the latter tries to sneak in unobserved through the Maze Pond entrance. Other scenes will doubtless occur to your fertile brains as they do to mine, but, for various reasons they cannot be set out in print.

The A.H.P.'s have received another letter from the gentleman, a sample of whose literary efforts I gave some weeks ago. This is it—

"Mr. Shaw. *Honourable Esteem Sir.*"

I am Receiveing great Pleasure in my Mind in Fulfiling My Desire, Returning Sincere Thanks To your generous Goodness, as i much Appreciate your Goodness Towards me as a Thorough True Fealing Gentleman For the Troble and the Care you Fully Bestows To Myself unto all the Patients For the better Improvement of Our Health We all feal most Anxious To Derive grater Facultyes of Strength My Suggestions I cannot receive at Presence Such High Privaleges I have just the Same Fealing in Body No Change No Renewed Strength returns There's Nothing Impossible which may Come to Pass to Brighter Hopes of Happiness Yourself is Proveing so Very Good Most Excellent In Changeing the Medicin Very Thankful to your Kindness Sir Great Praise i give unto you For your Great Persevearences In trying to sea me become in better Health The great Quantity of Medicine i have taken with Attention Different kinds your Fully Prescribed for me To make a Stronger impression Upon the Top Part of the Body I am Truly Sorry To say The Medicin and Food does not Seem To take any Effect To any Improvement as yet Is Seems Hollow Sinking In No Strength returning To the Top Part of my Body Its right in the Nable just the very Same as Something Lost In its Fealings If i wanted Food I could not feal worser.

Your Humble Servant.

Guy's Hospital Clubs' Union.

COUNCIL FOR 1899–1900.

President: Dr. Frederick Taylor. Council: Mr. Davies-Colley, Dr. Shaw, Mr. Fripp, E. B. Dowsett, H. S. French, D. G. Greenfield, K. V. Trubshaw, F. E. Walker. Treasurer: Dr. Washbourn. Secretary: Mr. F. J. Steward. Assistant Secretary: F. G. Gibson. Auditors of Clubs' Union Accounts: Mr. G. B. Smith, H. L. Eason. Auditors of Constituent Institutions' Accounts: H. S. French, E. B. Dowsett.

Pass List.

University of Brussels.

DEGREE OF DOCTOR OF MEDICINE.

Norman Lavers.

Appointments.

CIVIL.

Byford, W. F., M.R.C.S., L.R.C.P. Lond., has been appointed Medical Officer and Public Vaccinator for the No. 1 Sanitary District of the Ruthin Union.

Featherstone, G. W. B., M.R.C.S., L.R.C.P. Lond., has been appointed Medical Officer of Health to the Paincastle Rural District Council.

Gruggen, W., L.R.C.P. Irel., L.F.P.S. Glasg., D.P.H. Camb., has been re-appointed Medical Officer by the South Mimms Rural District Council.

Knaggs, R. Lawford, M.D. Camb., F.R.C.S. Eng., has been appointed Honorary Demonstrator of Surgical Pathology by the Council of the Yorkshire College.

Luce, Richard Harman, M.A., M.B. Camb., F.R.C.S. Eng., has been appointed Honorary Surgeon to the Derbyshire Royal Infirmary.

Morrison, J. T. J., M.A., M.B. Cantab., F.R.C.S. Eng., has been appointed Professor of Forensic Medicine in the Mason University College, Birmingham, vice R. M. Simon.

Stringfellow, Ernest, L.D.S. Eng., has been elected Honorary Dental Surgeon to the St. Saviour's Home, Taunton.

Turner, Geo. A., M.B., D.P.H., has been appointed Assistant Medical Officer to Grahamstown Asylum, South Africa.

Sport.

The United Hospitals' Athletic Sports.

The thirty-third annual athletic meeting in connection with the United Hospitals was held at Stamford Bridge yesterday, when a charmingly fine afternoon favoured the occasion. Nevertheless, the attendance was not what it should have been, Guy's especially being poorly represented, having only besides our president, Mr. Clement-Lucas, two supporters on the ground. The weeding-out heats had been decided earlier in the week, but still there were eleven events down for decision, and an interesting afternoon's sport was provided. C. E. H. Leggatt again did great service for St. Mary's, but though he won for them the sprint, the high jump, and then the long jump, clearing on the last occasion 23ft 4½in, which sets up a record for the United Hospitals' fixtures, St. Mary's, for all that, had to surrender the coveted challenge shield, which they have held since 1896, to St. Bartholomew's. In this they were distinctly unlucky, for although H. E. Graham did a fine performance in the half-mile, which he won in 1min 59 2-5sec, which has never previously been equalled at these gatherings, and supplemented this by carrying off the mile, a distance that the Cantab is not in the habit of negotiating, J. E. Lascelles could hardly have been beaten in the quarter had he not had the bad luck to fall. Despite this, however, it was a keen struggle between Bart.'s and St. Mary's, for the honours were easy up to the three miles, which was the concluding item on the card. In this, however, St. Mary's were not represented, and B. N. Ash, by running second to A. E. Oakley, won for St. Bartholomew's the United Hospitals' Challenge Shield, which they had not held since 1894. For Guy's, Trail ran well in the half, but was unfortunate in having two such strong opponents as Graham and Coltart. Fremantle and Roper ran pluckily in the three miles, but failed to stay in the sprint at the finish. We hope next year to see Guy's men practising the weight, 33ft 10in ought to be easily beaten. The judging was shared by Messrs. G. R. Turner, H. M. Fletcher, A. F. Voelcker, and S. K. Holman, Mr. C. Herbert was the referee, Mr. P. Furnival took the times, and Mr. E. H. Pelling was the starter, and the arrangements generally reflected much credit on Mr. C. H. R. Coltart, the hon. sec. Details:

100 YARDS CHALLENGE CUP.—Final heat: C. E. H. Leggatt, St. Mary's, 1; F. W. Syme, Guy's, 2; T. St. Clair Smith, St. George's, 3; W. A. Ward, St. Thomas's, 4. Leggatt led practically the whole way, and won by two yards from Sime, who just beat St. Clair Smith for second place. Time, 11sec.

HALF-MILE CHALLENGE CUP.—H. E. Graham, St. Bartholomew's, 1; C. H. R. Coltart, Westminster, 2; J. A. Nixon, St. Bartholomew's, 0; G. R. Wilson, London, 0; H. D. Trail, Guy's, 0. Nixon made most of the running till the bell sounded, when Coltart went to the front, but passing the grand stand he had to resign the lead to Graham, who eventually won by two yards. None of the others finished. Time, 1 min., 59 2-5 sec.

PUTTING THE SHOT.—A. E. Lister, St. Bartholomew's, 33ft 10in, 1; R. F. C. Thompson, St. Thomas's, 32ft 2in, 2; A. J. West, St. Bartholomew's, 32ft 4in, 3. Also competed: G. E. Orme, St. George's; R. C. Mullins, Guy's; N. D. Trail, St. Thomas's; and A. E. Martin, St. Thomas's.

120 YARDS HURDLE RACE CHALLENGE CUP.—Final heat: W. M. Fletcher, St. Bartholomew's, 1; C. E. H. Leggatt, St. Mary's, 2; L. D. Bailey, St. George's, 3; S. Carter, St. Thomas's, 4. Fletcher led the whole way, and won by three yards; about the same distance separated the second and third. Time, 16 3-5sec.

220 YARDS CHALLENGE CUP.—Final heat: F. W. Sime, Guy's, 1; T. St. Clair Smith, St. George's, 2; W. A. Ward, St. Thomas's, 3; T. Bates, St. Bartholomew's, 4. It was a good race between Sime and St. Clair Smith until twenty yards from home, when Sime drew away and won by a yard; a yard and a half divided the second and third. Time, 24sec.

HIGH JUMP.—C. E. H. Leggatt, St. Mary's, 5ft 7¾in, 1; J. L. Lascelles, St. Mary's, 5ft 6¾in, 2. Also jumped: H. B. Butler, St. Bartholomew's, and S. Pern, St. Thomas's.

THROWING THE HAMMER.—C. I. Graham, St. Mary's, 99ft 11in, 1; W. M. Fletcher, St. Bartholomew's, 97ft 4in, 2; A. J. West, St. Bartholomew's, 91ft 4in, 3.

ONE MILE CHALLENGE CUP.—H. E. Graham, St. Bartholomew's, 1; E. F. Fisher, London, 2; F. S. Lister, St. Bartholomew's, 3; J. M. Burgess, St. Mary's, 0; J. L. Gilks, St. Thomas's, 0; L. G. Nash, Guy's, 0; Graham cut out the work from the start, and at the bell he drew away, with Lister and Fisher only threatening any danger. Coming down the straght he left his rivals, and won easily by fifteen yards. Lister was a bad third. Time, 4min 50 4-5sec.

LONG JUMP.—C. E. H. Leggatt, St. Mary's, 23ft 4½in, 1; B. N. Ash, St. Bartholomew's, 18ft 11½in, 2; S. Pern, St. Bartholomew's, 3; F. E. Murray, St. Bartholomew's, 0. Leggatt's performance beat all previous records for the Hospital meetings.

440 YARDS CHALLENGE CUP.—T. St. Clair Smith, St. George's, 1; L. D. Bailey, St. George's, 2; T. Bates, St. Bartholomew's, 3; H. A. West, St. Thomas's, 0; J. E. Lascelles, St. Mary's, 0. St. Clair Smith cut out the work at the start, but going up the back stretch, Lascelles unfortunately fell. A little later both Bailey and Bates passed St. Clair Smith, but on entering the straight for home the St. George's man came again, and regaining the lead fifty yards from the tape, he finally won by about five yards; half a dozen yards divided the second and third. Time, 53 4-5sec.

THREE-MILE CHALLENGE CUP.—A. E. Oakeley, Middlesex, 1; B. N. Ash, St. Bartholomew's, 2; J. C. Mills, Middlesex, 3. Also ran: F. E. Fremantle, Guy's; R. S. Roper, Guy's; R. E. Brayne, Guy's; F. S. Lister, St. Bartholomew's; G. M. Levick, St. Bartholomew's; A. C. Birt, St. Thomas's; E. F. Fisher, London; E. M. Ridge,

London; and F. Coke, St. George's. Oakeley led the field for a while, but the pace was very slow, as will be evident from the fact that his time for the first mile was 5min 42sec. They continued altogether until a mile and a half had been traversed, and then Fremantle took up the running from Oakeley and Lister, and at two miles (11min 26sec) he was still showing the way. There was little alteration in the order afterwards, until the bell sounded, and then Oakeley came away with Lister, Ash, and Mills in close attendance. Just before making the turn for home, Ash drew right away, but coming down the straight Oakeley wore him down, and won eventually by eight yards, while about the same distance divided the second and third. Time, 16min 55 4-5 secs.

Cricket

GUY'S v. REIGATE PRIORY.

Played at Honor Oak Park, Saturday, July 1st. The visitors arrived three short, but after an exciting finish managed to win by 4 runs. They won the toss, and, thanks to a fine innings of 101 by F. J. Nightingale, made 179. Hicks bowled best for us, and took 3 wickets for 25 runs. Guy's began very badly, losing 2 wickets for no runs; 4 were down for 28 when Willan joined Poyser. A good stand was made, and 82 runs added before Poyser was caught for a useful innings of 53. With Morris in there seemed every chance of the runs being hit off, but Willan was unluckily run out, and Morris caught soon after, having played well for 25. Cowper hit well, but there was no one to stay with him, and the innings closed for 175. Scores:—

REIGATE.

F. Nightingale, b Cowper	2
F. C. Morrison, c & b Trubshaw	1
F. J. Nightingale, c Graham Smith, b Hicks	101
W. A. Windsor, b Trubshaw	7
Rev. G. C. May, b Trubshaw	25
G. G. Windsor, b Hicks	10
R. E. Drake, c Morris, b Hicks	20
A. P. Douglas, not out	20
Extras	12
Total	179

GUY'S.

G. S. Graham Smith, c Windsor, b Morrison	0
R. C. Poyser, c Windsor, b Nightingale	53
K. V. Trubshaw, b Morrison	0
H. M. Langdale, c Windsor, b Morrison	11
S. C. Bowle, b Morrison	4
G. T. Willan, run out	55
H. Morres, c Windsor, b Morrison	25
H. R. Grellet, b W. A. Windsor	2
J. T. Hicks, c Nightingale, b Morrison	1
C. M. L. Cowper, not out	15
E. W. Strange, lbw Morrison	1
Extras	8
Total	175

GUY'S v. BRENTWOOD.

Played at Honor Oak Park, on Saturday, July 8th, Guy's won the toss and started batting; no one but Langdale seemed able to stay in for long and 9 wickets were down for 108. Strange came in and once more kept up his end in great style whilst 72 runs were added. Langdale hit brilliantly, scoring 13 fours in his fine innings of 83 not out. The innings closed for 180. R. T. Thornton's underhand lobs proved very deadly, five men falling to them. Brentwood, going in, scored very slowly at first, till Thornton and Lewis got together. Our fielding for some unknown reason became very slack, and several catches were dropped. This seemed to demoralise the bowling, and our total was passed with 7 wickets to spare. R. T. Thornton played a good innings of 76. Scores:—

GUY'S.

G. S. Graham-Smith, c Eley, b Claughton	15
F. C. Wetherell, b Claughton	9
R. C. Poyser, b Thornton	17
J. M. Brydone, lbw, b Claughton	2
H. M. Langdale, not out	83
G. T. Willan, c Thornton, b Claughton	3
S. C. Bowle, b Heatley	12
K. V. Trubshaw, lbw, b Thornton	7
H. A. Grellet, b Thornton	0
C. M. S. Cowper, c & b Thornton	8
E. W. Strange, b Thornton	10
Extras	14
Total	180

BRENTWOOD.

C. H. Escott, c Graham-Smith, b Bowle	20
D. Crossman, b Cowper	17
R. T. Thornton, c Willan, b Strange	76
C. E. Lewis, not out	48
A. E. Heatley, not out	10
Extras	11
Total	182

L. Hollebone, Major Claughton, T. Hollebone, C. M. Lewis, Eley, and Lees did not bat.

United Hospitals' Rifle Association.

The following team was chosen to represent the Hospital in the Inter-Hospital Cup Competition, at Bisley, on Thursday, July 13th:—L.-Corpl. S. Hodgson, Pte. A. Pearson, Pte. B. W. Moss, Pte. G. Lewin, Artist's R.V.; Pte. J. A. Glover, Pte. D. H. Traill, London Scottish R.V.

The advent of "Bisley Week," with its Inter-Hospital competition, naturally brings rifle shooting at Guy's to a close. In a club like ours, where the sporting element of shooting alone holds place, it is essential that the season's arrangements should culminate in a point of highest interest, and this end is best observed by arranging matters so that the last fixture on the card shall be

the Inter-Hospital contest. When this GAZETTE is published, the fate of the Shooting Cup will be decided, and our Rifle Club will drift back into oblivion until next spring.

But before the faint flicker of interest which the hospital in general takes in this particular club dies out completely, a few remarks on the current year may be of value, if not in attracting new members, at any rate in correcting certain erroneous statements indulged in by, mostly incompetent, critics.

It must be at once admitted that this season has been anything but successful. We have not had a dearth of shooting men, nor an absence of keenness among the old hands, but chiefly a combination of unfortunate circumstances. In the first place, the Hon. Secretary satisfied the College examiners in all three subjects, and at once went forth to enjoy his new-found freedom. His resignation of office was sudden and unexpected, and, as is usual in these cases, a man was not forthcoming immediately who was prepared to carry on the work. Consequently there was a momentary stagnation in the current of events, and one or two fixtures were abandoned simply because the man who had made all arrangements was not at hand to explain and complete the scanty information which was available.

Before his resignation, however, one fixture was met which was extremely satisfactory. On a perfectly "fair" range, at Wraysbury in fact, six Guy's Volunteers met six Guy's non-Volunteers and defeated them by a small margin. Of the non-volunteers it is only fair to say, however, that only one had never worn uniform. The rest were all old hands, with, in several cases, considerable reputations behind them. Apart from the enjoyable nature of the match, it was extremely gratifying to find that after numerous refusals, we could still put twelve men in the field. The general average of shooting was not high, but the difficult conditions of light and wind were quite sufficient to account for this.

After that match it appeared likely that the Challenge Cup would remain in the smoking-room for another year. Our team, allowing that no new man won a place by better averages, worked out to be identical with that of last year's when we beat St. Thomas's. At the very least we were as good as, and with additional practice we expected to be better than we were last year. But then the Secretary resigned and matters began to look less rosy. In the chaos which followed, it was difficult to try new men for the vacant place. However, several were given trials, but the result was not very promising. Then Travers, who showed such excellent form last year, found that he would be unable to come down from Durham for the match, so that we rapidly approached the Bisley week with but four assured men. Then came the real trouble. Various men were tried, but no heaven-born rifle-shot could be found. Men there were who could make a fair shoot on a good day, but it was necessary to face the contingency that the competition would be shot on a gusty, cloudy day, when experience alone could prevent a man from going entirely to pieces.

At last, on the eve of the shoot, a team has been chosen which is certainly the best available. All of the men in the team can make scores, and all have had experience of fair and foul weather. Whether they will succeed in retaining the cup is another matter; if they do, the victory will be still more meritorious from the fact of the numerous obstacles which have lain in their paths. If they do not we can only say, better luck next time.

Guy's Hospital Lawn Tennis Club.

INTER-HOSPITAL JUNIOR LAWN TENNIS TOURNAMENT.—FIRST ANNUAL MEETING.

ST. GEORGE'S FIRST HOLDERS OF THE WASHBOURN CUP.

Played in showery and gusty weather at Honor Oak Park, on Saturday, July 1st. Four hospitals sent teams, of which St. George's proved easily the best, and St. Thomas's the worst, London just beating us for second place by virtue of its first pair, who were the best pair on the field. The tournament is open to men in their year who have not played in the cup ties this season; and may therefore be taken to include the first teams of hospitals which do not put in for the cup ties. Some day, doubtless, the Royal Eye will send a team.

Dr. Washbourn has provided a handsome cup of silvered copper, designed by the Guild of Handicraft, in the Mile End Road, so as to indicate by its size that it is a junior prize and by its beauty that a challenge cup may be a work of art. The design was presented to the captain of the winning team, and the cup, when complete, will be on view for a few days first in Guy's.

The tournament, despite unsuitable weather, was a great success, and resulted in some very good games. It was, of necessity, played on the American system, every pair playing each pair of every other hospital eleven games. Each pair therefore played 99 games; of which Wilson and Limay, the first London pair, scored 75; the three George's pairs coming next with an average of 65; and our first pair fifth, with a score of 56. In the end the score was St. George's 195, London 148, Guy's 144, and St. Thomas's 98. We have been unlucky this season in being deprived of the services of several good men, Rowland, the Wetherells, Crosse, Willan, Ransford, and Swan; but probably other hospitals have had very similar experiences; and it is indeed rather surprising that this venture of second sixes at lawn-tennis should have proved so successful as it has in this its inaugural year. Our team were:—F. E. Fremantle (capt.) and C. D. Pye-Smith, J. S. Steele-Perkins and T. E. Holmes, C. A. E. Ring and H. C. Winckworth. Fremantle is in his last year, but the others should all be available next year. Pye-Smith, with a permanent partner, as he had this year until Wedd was promoted, and with experience, should develope. Steele-Perkins has improved considerably this year. Holmes plays a good single game, but in doubles does not come up enough to the front. Ring has

the best style of the team and if he took the trouble, could make a very good player. Winckworth has some good strokes, but is variable.

GUY'S v. STAFF.

Played at Honor Oak Park, on Thursday, June 29th, and resulted in a win for the hospital by 7 matches to 4. A most enjoyable afternoon was spent, and reference to the scores below show that many of the matches were evenly contested. The thanks of the team are due to Mrs. Shaw, both for the excellent tea and for the admirable way in which she presided at the tea table.

Score.—P. S. Mandy and E. N. Jupp beat Drs. Starling and Hyslop, 11–9, 7–5; beat Drs. Beddard and Spriggs, 6–3, 6–2. H. K. Lacey and F. E. Fremantle lost to Drs. Starling and Hyslop, 5–7, 7–5, 6–8; lost to Drs. Beddard and Spriggs, 1–6, 6–2, 3–6; beat Drs. Shaw and Bryant, 6–2, 6–2. F. B. Manser and L. Cooke lost to Drs. Beddard and Spriggs, 0–6, 6–8; beat Drs. Shaw and Bryant, 6–2, 6–3; lost to Drs. Washbourn and Stevens, 4–6, 2–6. C. A. E. Ring and H. B. Wedd beat Drs. Shaw and Bryant, 6–2, 6–3; beat Drs. Washbourn and Stevens, 6–4, 6–3; beat Drs. Starling and Hyslop, 2–6, 6–4, 8–6.

United Hospitals' Swimming Meeting.

The finals of the Inter-Hospital Competition in swimming and water polo were decided at the Bath Club on Tuesday last, the members of that club having kindly placed the bath at the disposal of the committee. There was a large assembly present, including many ladies.

The first event was the final of the Swimming Cup Ties, each side being represented by a team of four. St. Mary's, the holders, retained possession, beating Westminster somewhat easily. This was followed by the final of the Water Polo Competition, in which St. Bart.'s, last year's winners, were opposed by Guy's. We lost the toss and started from the shallow end. A foul was awarded in the middle of the bath, and Bart.'s quickly scored their first goal. They continued even for a short time, when Edwards got possession of the ball, and rapidly leaving his man, finished the best piece of play in the match by equalizing with a really good shot. We missed an easy chance to score just before half-time, and crossed over with the score unchanged.

During the second half, Bart.'s had undoubtedly the best of the game, but the play was marred by many fouls. Wilkes saved many shots in fine form, but Bart.'s, after much wild shooting, scored the winning goal. The whistle blew with nothing else scored, so Bart.'s retained possession of the Cup by two goals to one.

The game was a keen one, but it is much to be regretted that many fouls, some most flagrant, and other objectionable incidents, should occur in a hospital match. Team;—

Guy's.—J. H. Wilkes, R. Franklin, D. H. Trail, H. N. Crosse, J. R. S. Ash, A. C. Edwards, D. E. Greenfield.

After a good display of fancy swimming, the members of the Bath Club gave a display of the Water Journey, in which Dr. Higgens figured prominently. The evening was concluded by the presentation of prizes by the Duchess of Portland.

After the guests had departed a match was arranged between Mr. Fripp and the late captain of the Bart.'s team, who failed to give our President three seconds' start in a two lengths race.

Papers by Guy's Men.

Some Cases of Malignant Disease associated with Ovarian Tumours. By John D. Malcolm, M.B., F.R.C.S. —*Lancet*, 17th June.

Injuries produced by the Explosion of Gun-cotton. By Gerald Sichel, F.R.C.S., R.N.

From the Gazette's Special Pathologist.

J. J. C., Bridlington Quay.—The growth on blood serum after incubation contains staphylococci and streptococci. The Klebs-Löffler bacillus was not found in it.

PATHOLOGIST.

Births.

CAPES.—On July 6th, at Grove Lane, Denmark Hill, S.E., the wife of Robert Capes, of a daughter.

ROBERTS.—On June 23rd, at Badlesmere, Eastbourne, the wife of Astley Roberts, M.R.C.S., L.R.C.P. Lond., of a son.

Marriage.

COLCLOUGH—JAMES.—On June 28th, at St. Andrew's Church, Broadhembury, near Honiton, Devon, by the Rev. Charles Lister James, M.A., Vicar of the Parish, brother of the bride, W. Frank Colclough, B.A., M.B., B.C. Cantab., etc., Medical Officer to the British Hospital, Oporto, eldest son of William Colclough, of 103, Central Hill, Upper Norwood, of "The Manor," Honor Oak, S.E., to Florence Trene, fourth daughter of the late W. Rhodes James, of Pinhoe, near Exeter.

Deaths.

DAVIES.—On July 3rd, suddenly, at Caswell Bay Hotel, Mumbles, Swansea, Henry Raunton Davies, J.P., Surgeon, of Glyn Rhondda House, Porth, Rhondda Valley, South Wales, in his 72nd year.

SWABY-SMITH.—On July 2nd, at 124, Mill Lane, West Hampstead, N.W., Dr. L. Swaby-Smith, in his 65th year.

Ed.—F. E. W.

Contents.

	PAGE
SCARLATINAL ARTHRITIS: Clinical Lecture by Dr. Washbourn	309–312
HOSPITAL NEWS	312–315
SOLUTION OF CASE FOR DIAGNOSIS	315
A CASE OF HENOCH'S PURPURA: By C. P. T. Maisey, M.R.C.S., L.R.C.P. Lond.	315–316
CORRESPONDENCE: The late B. F. Henry	316
OBITUARY: Dennis Adams, J.P., M.R.C.S. Eng.	316–317
GUY'S HOSPITAL DEBATING SOCIETY	317–318
NOTICES	318
PAPERS BY GUY'S MEN	318
NURSING NOTES	318
PASSIM	319–320
ON THE DECLINE OF SCURVY: Paper by Surgeon C. Marsh Beadnell, R.N.	320–324
IN LIGHTER VEIN	324–325
MAINLY ABOUT NOTHING	326–327
PASS LIST	327
FROM THE GAZETTE'S SPECIAL PATHOLOGIST	327
SPORT: Cricket—Guy's v. Dunstable Grammar School; Guy's v. Brentwood. Guy's Hospital Bicycle Club. Guy's Hospital Lawn Tennis Club—Guy's v. Wanstead	327–328
APPOINTMENTS	328

Calendar of Coming Events.

July, 1899.

Sat. 29.—G.H.L.T.C. v. Wanstead, at Honor Oak Park. October appointment list now open.

August

Thur. 3.—Mr. Davies-Colley's take-in.

Thur. 10.—Mr. Lucas' take-in; Drs. A. G. Butler and A. C. Ransford.

Guy's Hospital Gazette,

JULY 29, 1899.

Scarlatinal Arthritis.

CLINICAL LECTURE BY DR. WASHBOURN.

July 12th, 1899.

GENTLEMEN,—I propose to-day to give you an account of two or three cases illustrating certain complications which arise in the course of Scarlet Fever.

Now, in considering complications of scarlet fever you must understand that in most cases of scarlet fever, there is a dual poison; there is what is generally termed a mixed inflammation. The one poison is the true virus of scarlet fever, and the other the streptococcus pyogenes, an organism which secondarily invades the tonsils. You can distinguish in scarlet fever two main types of the disease, the one which is due to the effects of the true scarlatinal virus, and the other chiefly due to the effects of the streptococcus.

Cases of scarlet fever occur in which, apparently, only the true scarlatinal virus is present. Many of these cases are mild, but now and then fatal cases of so-called toxic scarlet fever occur, in which the patient dies from the effects of the scarlatinal virus, and in which no organisms are found in the tissues, because the means which we have at the present time at our disposal are insufficient for recognising the scarlatinal virus. You must remember that the true cause of scarlet fever has never yet been ascertained; it has never been found microscopically or by cultivation, and all we know about the virus is the manner in which it behaves under various conditions.

The other type of scarlet fever is the septic form, in which the streptococcus invades the fauces, tonsils, and palate, and produces various symptoms. Patients may die from septicæmia caused by this streptococcus when they are not very severely affected by the true scarlet fever virus.

Some complications of scarlet fever are due to the scarlet fever virus, and some to the streptococcus. For instance, an early adenitis is generally due to the streptococcus; a late adenitis to the true scarlatinal virus. Nephritis may be due either to the scarlatinal virus or to the streptococcus. I will read you the notes of the cases.

CASE I. *Scarlatinal arthritis.*—The patient was a female, eight years old, who on November 8th had a sore throat and a rash. The disease was diagnosed as scarlet fever. On the 12th, four days later, she complained of pains in the joints; and on the 13th the wrists were swollen. On the 16th she was admitted into the London Fever Hospital. On admission, the rash had disappeared, but the tonsils were still red and swollen; both wrists were swollen and tender; the temperature was 103°. The patient was put upon salicylate of soda; after about a couple of days the temperature went down, and she was convalescent. As the temperature subsided the pains in the joints disappeared.

CASE II. *Acute rheumatism arising during scarlet fever.*—Patient was a boy, eleven years of age. Some time ago he was ill for a few days with pains in his legs, no doubt an attack of rheumatism, and he had suffered from time to time from shortness of breath. On the 5th of May he was seized with headache, sore throat, vomiting, and the usual initial symptoms of scarlet fever. On the 9th, four days later, a rash was observed, and he was admitted on the following day. On admission, there was a well-marked rash, the tonsils were swollen and showed points of exudation; there was slight enlargement of the glands at the angle of the jaw; the pulse was 104, temperature 100·4°,

and there was a distinct systolic bruit audible at the apex. For the next few days there was nothing particular to note. The temperature gradually came down, and by the fourteenth day of the illness it had become normal. But on the twenty-fifth day he complained of pains in both wrist-joints, which, however, were not swollen. The next day he still complained of pain in the joints, and the temperature went up to 101°. The pain increased, and passed from one joint to another, the wrist, knees, and the hip-joints being affected. He was put upon salicylate of soda, and after the temperature had been up for some four or five days it went down, and he convalesced.

Case III. *Scarlet Fever—Streptococcal arthritis—Septicæmia—Death.*—The patient, a girl, five years of age, was taken ill on the 7th of May, and admitted into the Fever Hospital four days later, on the fifth day of the disease. On admission, the rash was fading; there was a granular condition of the fauces, but no definite ulceration. The glands at the angle of the jaw were slightly enlarged, the temperature was 102°, and the child seemed ill; it was peevish, ill-nourished, and pale. The temperature went up to 104° the next day. Subsequently there was discharge from the ears and a little ulceration on one of the tonsils. On the sixth day after admission, the eleventh day of the disease, the child was seized with a rigor in which the temperature went up to about 103°, having been just before that almost normal. She complained of pain in the left knee, which, however, was not swollen. On the next day the child appeared to be worse, and there was perhaps a little puffiness about the knee, but no definite swelling. Septic arthritis was diagnosed, and some anti-streptococcal serum (30 c.c.) was injected. The next day there was more tenderness about the knee, and possibly some fluid present. No other joints were affected, the temperature still kept up, varying between 102° and 104°, and the child seemed badly. Another injection of serum was given. The following day she vomited a little. The next day the knee was less puffy, but there was slight effusion into both wrist-joints. On the succeeding day the patient became very irritable, constantly screaming; slight twitching of the face was noticed and there was occasional vomiting. On examining the optic discs we found there was commencing neuritis. The next day there was marked twitching of the face and the limbs, and there was slight retraction of the head. The knee affection had apparently subsided, but the wrists remained puffy. During the next three days three doses of serum were given, the twitching disappeared, but the knee again became distinctly swollen with effusion of fluid. The joint was explored with a syringe, serous exudation was drawn off and some anti-streptococcal serum injected directly into the joint. The fluid from the joint contained a large number of streptococci. On the next day the child was worse and there was more swelling about the knee; hæmorrhages appeared in the subcutaneous tissue on the thigh and the leg. On the following day the knee-joint was explored and a lot of fluid, at first clear and later purulent, was drawn off; the joint was irrigated and a drainage tube inserted. During the day a great many more hæmorrhages occurred into the skin; blood and casts were passed in the urine. The knee-joint oozed a great deal, and there was great difficulty in stopping the bleeding. The child gradually got blanched, and died that evening.

A post-mortem examination revealed ecchymoses all over the serous membranes, and into the subcutaneous tissue. Both pelves of the kidney were full of blood, and the kidneys presented the appearance of acute nephritis. Streptococci were found, microscopically and by cultivation, in the lung, heart, spleen, liver, kidneys, and in the hæmorrhages into the subcutaneous tissue. There was, in fact, a general streptococcal septicæmia.

The main points about these three cases are as follows:—

The first case was that of a patient who, during the early days of convalescence from an ordinary attack of scarlet fever, was attacked with pain in the joints. Now, that is the usual period at which scarlatinal arthritis comes on. Scarlatinal arthritis is an inflammation of the joints of a mild nature, which does not pass on to suppuration, or give rise to any cardiac affection, and which yields to treatment with salicylate of soda. It probably is due to the true scarlatinal virus. But whenever pain or swelling in the joints arises in scarlet fever, three questions require consideration. Is the pain due to ordinary scarlatinal arthritis, to an attack of acute rheumatism occurring during scarlet fever, or to a septic arthritis caused by secondary infection with the streptococcus? These are very important questions, because the prognosis is different in these three conditions. A septic arthritis is a very serious matter; and acute rheumatism is serious, inasmuch as the heart may become affected; while ordinary scarlatinal arthritis is a matter of slight import.

In Case II. the patient had suffered from a previous attack of rheumatism, and there was mitral regurgitation, due, no doubt, to the previous rheumatism. The attack of scarlet fever was somewhat sharp, and the temperature became normal at the end of a fortnight. At the end of a little more than three weeks the patient began to suffer from pains in the joint, first in one and then in another. We considered the period too late for ordinary scarlatinal arthritis. The diagnosis rested between acute rheumatism and streptococcal arthritis. The history of previous rheumatism, and the yielding to treatment with salicylate of soda, decided in favour of acute rheumatism.

In Case III., although the rash was fading and the temperature was not high, nevertheless the patient appeared to be very ill. On examining the tonsils we found a dry, granular condition, which is frequently present in septic cases. After a time the tonsils ulcerated and the middle ear suppurated. On the eleventh day of the attack the child had a rigor, and at the same time complained of pain in the knee-joint. Although we could find no effusion, nevertheless we inferred that this was a case of septic arthritis, and the rigor assisted us very materially in coming to a conclusion. In ordinary acute rheumatism rigors are exceedingly uncommon, and in ordinary scarlatinal arthritis there is seldom any serious constitutional disturbance. After a time the child began to vomit, and show signs of cerebral irritation, occasional squint, optic neuritis, twiching of the muscles, etc., so that we thought it was getting a streptococcal infection of the meninges of the brain of a similar nature to that which was affecting the joint. It is a very interesting fact that for a time there was a disappearance of the effusion into the knee. That by no means infrequently occurs in septic cases, not only in septic cases of scarlet fever, but in other forms of septic arthritis. There arises inflammation of a joint, which subsides and then comes back again. After a time the swelling came back in the knee, and fluid was effused into the joint. The child gradually got worse, and hæmorrhages began to appear in the subcutaneous tissue. In addition to hæmorrhages in the subcutaneous tissue, blood appeared in the urine, and there was also some vomiting of blood from the stomach, so that there was considerable hæmorrhage occurring all over the body.

The knee was explored, turbid fluid was evacuated, and anti-streptococcal fluid was injected directly into the joint. The next day it was necessary to open the joint and put in a drainage-tube. The oozing of blood from the knee-joint continued, and the child died that very evening. At the post-mortem examination there were hæmorrhages in the subcutaneous tissue, also in the peritoneum, the pleuræ, and the pericardium; there was marked nephritis, and blood in the pelvis of the kidney. Streptococci were found in all these different parts, both microscopically and by cultivation.

The first point I want to draw attention to is the diagnosis of these three conditions—ordinary scarlatinal rheumatism, acute rheumatism occurring during the course of scarlet fever, and streptococcal arthritis.

Ordinary scarlatinal rheumatism generally occurs during the early stage of convalescence, just as the temperature begins to go down. It is, as a rule, quite mild, there is not marked effusion into the joints; it passes from one joint to another as in acute rheumatism; it yields to salicylate of soda; and it never gives rise to any affection of the heart or pericardium.

An arthritis occurring later may be either an attack of acute rheumatism or a septic arthritis. If it is acute rheumatism there will probably be a previous history of rheumatism, or some evidence of the heart having been affected. An acute rheumatism occuring during scarlet fever has all the ordinary characteristics of acute rheumatism, the patient may get endocarditis, and it yields to treatment by salicylate of soda.

A septic arthritis generally becomes localised in one joint. There is perhaps swelling of several joints at first, but it usually settles in one joint, and this joint usually suppurates. That is what happened in Case III. There was pain in the wrist-joint and the knee-joint. The pain disappeared from the wrist and knee for a time, but it came back to the knee, which suppurated. All this was attended by constitutional symptoms, rigors, and high temperature.

The question arises as to whether an injection of anti-streptococcal serum is of any good in these cases. You know quite well that there are many conditions which are due to streptococcal infection, many conditions which come under the name of pyæmia, septicæmia, etc. These conditions are generally due to the streptococcus pyogenes. This streptococcus is capable of producing pathogenic effects on animals by inoculation; and it is possible to immunise animals by injecting, first of all, cultivations that have been killed by heat, and then small doses of living cultivations. The blood-serum of these animals has the power of protecting other animals

against infection. The anti-streptococcal serum used for therapeutic purposes is obtained by immunising horses. The horse is chosen because it is an animal from which a large quantity of blood can easily be obtained, and because the serum is only slightly toxic to the human subject.

This serum certainly protects animals against some varieties of the streptococcus, but other varieties are not influenced at all by it. Anti-streptococcal serum has a most beneficial effect in some cases of septicæmia and septic trouble. I have even seen cases of ulcerative endocarditis due to streptococcal infection, which have been cured by an injection of serum; and in some cases of septic trouble there is no doubt that it has a very remarkable effect, but in other cases it does not appear to have the slightest influence. I may say that my experience is that streptococcal infections in scarlet fever are not influenced by the anti-streptococcal serum, at any rate, not influenced by the serum which is in use at the present time.

Another point of importance is this: Can the anti-streptococcal serum by itself produce any ill effects. Now, you must quite recognise the fact that the injection of the blood-serum of an animal into the tissues of the human subject is not unattended with danger. There is no question whatever that there is a certain amount of danger arising from an injection of serum, whether it is anti-streptococcal or anti-diphtherial, or whatever the serum may be. And we had doubts as to whether the hæmorrhagic condition that occurred in this case was not due to injection of the serum. Instances have been recorded in which the injection of protective serum, as a preventive measure, into the tissues of persons who are healthy, has given rise to fatal disease in which hæmorrhages have occurred in the different tissues, a purpuric condition which appears to be of a septic nature. These cases are exceedingly rare. Most cases in which hæmorrhages have occurred after the injection of serum have been attributed to the serum, but wrongly. In some cases of diphtheria, after an injection of serum, purpura has occurred, but you must remember that in diphtheria it is not altogether uncommon to meet with a purpuric condition quite apart from any injection of serum. And in cases where patients are suffering from septicæmia you know that purpura and hæmorrhages in the tissues are by no means uncommon. We examined the blood from the subcutaneous hæmorrhages with the object of finding out whether any streptococci were present, and from their presence we inferred that the hæmorrhages were due to infection with this streptococcus, and had nothing whatever to do with the injection of the serum. The serum appeared to have no influence either for good or for evil in this case.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

CASES UNDER DR. PYE-SMITH.

MARY	26.	Apical pneumonia.
	27.	Osteo-arthritis.
	29.	Empyema.
	30.	Tumor cerebri.
	31.	Tuberculous peritonitis.
	32.	Mitral stenosis and regurgitation.
	33.	Pneumonia.
	34.	Hysteria.
	35.	Pneumonia.
	36.	Hæmaturia.
	37.	Broncho-pneumonia.
	Cot 5.	Broncho-pneumonia. Marasmus.
PHILIP	21.	Rheumatism.
	23.	Tuberculous peritonitis.
	24.	Sub-acute nephritis.
	26.	Mitral stenosis and regurgitation.
	27.	Gout.
	28.	Diabetes. Peripheral neuritis. Phthisis.
	29.	Stricture of œsophagus. Empyema.
	30.	? Appendicitis. Æt. 60.
	31.	Carcinoma of stomach and colon. Gastro-enterostomy and colotomy.
	32.	Renal tumour.
	33.	Nephralgia.
	35.	Broncho-pneumonia.
	37.	Ascites. Carcinoma of stomach.
	38.	Rheumatism.
	40.	Double aortic disease. Mitral regurgitation.

CASES UNDER DR. TAYLOR.

MARY	38.	Neuritis.
	39.	Growth in liver. Primary rectum.
	40.	Grave's disease.
	42.	Acute rheumatism.
	43.	Phthisis.
	46.	Pleuritic effusion.
	48.	Abdominal tumour.
	49.	Ascites.
	Cot 56.	? Acute tuberculosis.
	57.	Bright's disease.

STEPHEN
2. Aortic disease.
4. Acute rheumatism. ? Gout.
7. Mitral disease.
9. Diabetes mellitus.
10. Sciatica.
11. Gastric ulcer.
13. Enteric fever.
15. Enteric fever.
17. Diabetes.
18. Recurrent pneumonia.
19. Locomotor ataxy.
20. Appendicitis.

CASES UNDER DR. HALE WHITE.

MARY
13. Chorea.
14. Gastric ulcer.
15. Congenital heart. Patent ductus arteriosus.
16. Pleurisy with effusion.
17. Mitral stenosis.
18. Phthisis.
19. Hysteria.
20. Erythema nodosum.
21. Chlorosis.
22. Tumor cerebri.
23. Pleurisy. Pericarditis.
24. Mitral stenosis.
53. Broncho-pneumonia.
54. Tuberculous peritonitis.

PHILIP
1. Rheumatism.
2. Typhoid.
3. Multiple malignant growths.
4. Infective endocarditis.
6. Carcinoma of stomach.
7. Lead colic. Gout.
8. Chronic nephritis.
9. Empyema.
10. Phthisis.
11. Diabetes.
12. Carcinoma of stomach.
13. Malaria.
14. Eczema.
15. Chronic nephritis and emphysema.
16. Pyrexia. ? Cause.
17. Ptomain poisoning.
18. Rheumatism.
19. Dropsy. Emphysema.
20. Collapse. ? Insolation. T. 104°.

"Clinical."

2. Cerebral hæmorrhage.
3. Aortic regurgitation. Angina.
4. Cancer of rectum. Secondary enlargement of liver.
6. Perinephritic abscess.
8. Anæmia. Splenic enlargement.
10. Subdiaphragmatic abscess.
11. Hepatic abscess. ? Actino mycosis.
13. ? Carcinoma ventriculi.
14. Fæcal impaction.
15. Syphilitic stenosis of bronchi.
16. Pneumonia.
19. Double aortic and mitral disease.
21. Rheumatism. Pericarditis.
22. Puerperal pyæmia.
24. Ovarian cyst.
25. ? Enteric.
26. Cerebro-spinal meningitis.
27. Malignant sigmoid. Perforation of cæcum. Operation.
28. Hydatid of liver. Perforating into lung.
29. Cancer of stomach.
30. Pericarditis.
31. Infantile paralysis.
32. Dropsy. Large liver and spleen. Bronchitis.
33. Diphtheria. Tracheotomy.
34. Broncho-pneumonia. Fits. ? General tuberculosis.
35. Broncho-pneumonia. Rickets.
36. Lobar pneumonia.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

NAAMAN
3. Old tuberculous hip with abscess.
4. Old excision of tuberculous hip with sinus. Furneaux-Jordan's amputation.
5. Tuberculous tarsus. Scraped.
6. Tuberculous knee.
8. Enlarged prostate. Supra-pubic puncture.
9. Sarcoma testis. Castration.
10. Cancer of rectum. Inguinal colotomy.
11. Caries of ribs. Pectoral abscess. Incised.
13. Appendicular abscess. Fæcal fistula.
14. ? Gummatous epididymitis. Castration.
16. Empyema. Previous drainage. Ribs resected.
18. Ankylosed hip.

DORCAS
3. ? Renal calculus. Nephrotomy.
4. Strangulated femoral hernia. Kelotomy.
5. Fractured left femur. Hodgen. Fractured right tibia and fibula.
6. Gummatous ulceration over and arthritis of elbow.
7. Vesical calculus.
8. Carcinoma mammæ. Excised.
11. Strangulated femoral hernia. Kelotomy.
12. Hysterical dysphagia.
13. Fractured femur. Hodgen.
14. Carcinoma mammæ. Excised.
15. ? Tuberculous. ? Syphilitic arthritis of knee. Amputation through thigh.

Astley Cooper 1. Ruptured urethra. Perineal section.
2. Compound fracture tibia and fibula. Wired.
6. Fractured ribs.
7. Crushed hand. Amputation through forearm.
9. Fractured femur.
25. Fractured ribs.
28. Compound fracture of tibia and fibula.
32. Stab in abdomen. Penetrating.

Cases under Mr. Davies-Colley.

Job 2. Epithelioma in old scar (? lupus). Tumour excised. Secondary deposits in axilla.
3. Ununited fracture of tibia with necrosis. Sequestrotomy.
5. Tuberculous knee. Excised.
6. Tuberculous knee. Excised.
7. Halluces valgi and bunions.
9. Retention ? Prostatic.
10. ? Renal calculus.
20. Old excision of knee. ? Locomotor ataxy.
21. Anthrax. Pustule excised.
22. Mastoid abscess. Antrectomy.
24. Cyst on forearm. Excised. ? Sebaceous with hæmorrhage into it.
25. Bullet in forearm. Extracted.

Lydia 1. Gummatous ulcers on leg.
2. Tuberculous shoulder. Incised.
3. Fractured patella. Splints.
4. Tuberculous hip. Excised.
5. Strangulated umbilical hernia. Kelotomy.
7. Rodent ulcer on forehead. Excised.
8. Strangulated femoral hernia. Kelotomy.
11. Lymphangeiomata of cheek.
12. Rodent ulcer of nose. Recurrent. Excised.
13. Fractured pelvis.
16. Fractured clavicle.
17. Adenoids and enlarged cervical glands.
18. Genu valgum.
Cot A. Cleft palate and hare lip.
B. Cleft palate and hare lip. Plastic operation.

Cases under Mr. Lucas.

Lazarus 1. Recurrent sarcoma of crureus. For Coley's fluid.
2. Spinal caries.
3. Double inguinal hernia. Reducible.
4. Acute appendicitis.
5. Ankylosed hip. ? Tuberculous. ? Gonorrhœal.
6. Melanotic sarcomatous glands in neck. Excised. No obvious primary cause.
8. Old mastoid abscess.
10. Stricture.
17. Mastoid abscess. Antrectomy.
18. Irreducible inguinal hernia.
19. Epithelioma of cheek on scar of lupus erythematosus. Excised.
20. Recurrent epitheliomatous glands in neck. Excised.
22. ? Anthrax.

Martha 1. Cleft palate. Plastic operation.
2. Recurrent carcinoma mammæ. Oophorectomy previously. No benefit.
3. Pott's fracture.
4. Sarcoma mammæ.
5. Tuberculous elbow. Excised.
14. Recurrent cancerous axillary glands. Œdema of face.
15. Talipes equino-varus. ? Congenital.
16. Compound fracture of tibia and fibula.
19. Bullet in brain. Extracted.
21. Calculous pyonephrosis. Nephrolithotomy.
Cot A. Fracture of humerus. Supra condylar. T-shaped.
B. Hare lip.

Astley Cooper 8. Compound fracture of tibia and fibula.
15. Fractured patella. Wired.
22. Fractured femur. Hodgen.
23. Supra condylar fracture of femur.
24. Fractured femur. Double Bryant.
25. Fractured dislocation of spine. Sixth dorsal.
27. Ruptured intestine. Resection.

Cases under Mr. Golding-Bird.

Luke 1. Irreducible inguinal hernia. Radical cure.
6. Moveable kidney. Nephrorraphy.
7. Necrosis of radius.
8. Old dislocation of elbow excised.
10. Extravasation of urine. Died.
11. Anthrax.
13. Stricture with retention.
14. Mastoid abscess. Antrectomy.
16. Sarcoma of neck. Excised.
17. Mastoid abscess. Antrectomy.
18. Old infantile paralysis. Syme.
20. Gonorrhœal synovitis of knee.
21. Tuberculous elbow. Excised.

Charity 2. Calculous pyonephrosis. Nephrolithotomy.
3. Strangulated femoral hernia. Kelotomy.
4. Umbilical hernia. Radical cure.
5. Burns.
6. Cystic breast. Amputated.
7. Suppurating hæmatoma on thigh.
8. Sarcoma of breast. Excised.
9. Ruptured urethra.
10. Concussion. Epistaxis and aural hæmorrhage.

CHARITY 11. ? Carcinomatous. ? Fibrous structure of rectum.
13. Fractured base. Trephined. Death.
14. Sarcoma of femur. Amputation through thigh.
16. Appendicular sinus.
17. Paget's nipple. Breast excised.
18. Rodent ulcer. Excised.
Cot A. Lumbar abscess.
B. Tuberculous metatarsus.
ASTLEY COOPER 4. Fractured anatomical neck of humerus.
12. ? Fractured neck of femur.
19. Fractured femur.
29. Cut throat.
CORNELIUS 7. Fractured base. Lacerated brain. Death.
6. Fractured clavicle and ribs. Acute pneumothorax. Death.
16. Ruptured intestine. Resection. Death.
16. Bullet in arm.

CASES UNDER MR. JACOBSON.

NAAMAN 21. Suppurating hæmatoma on thigh.
DORCAS 19. Right reducible inguinal hernia.
21. Trigeminal neuralgia. Lingual nerve resected.
Cot D. Rachitic tibiæ.

CASES UNDER MR. SYMONDS.

JOB 14. Stricture. Urethral. Traumatic.
15. Recurrent sarcoma of lower jaw. Excised. Primary growth in maxilla.
16. Sarcoma of tonsil and glands. Excised.
17. Nasal polypi.
18. Carcinoma laryngis. Tracheotomy.
19. Lympho-sarcoma of fauces with glands involved. *Coley's fluid.*
LYDIA 21. Mammary duct abscess.
22. Kraske's excision of rectum.
RUTH 26. Occlusion of larynx. Post scarlatinal.
35. Nasal polypi. Frontal sinus empyema.

CASES UNDER MR. LANE (Mr. Fripp acting).

LAZARUS 11. Appendicular fæcal fistula.
12. Otitis media. Cerebellar abscess.
13. Hæmorrhoids. Whitehead's operation.
14. Tuberculous testes. Castration.
MARTHA 10. Moveable kidney. Nephrorraphy.
11. Periosteal abscess of jaw. Drained.
12. Irreducible umbilical hernia.
Cot C. Talipes equino-varus.

CASES UNDER MR. DUNN.

LUKE 2. Recurrent epitheliomatous glands. Excised.
3. Recurrent epitheliomatous glands in neck extending to axilla. Secondary to lip.
LUKE 11. Enlarged prostate: vasectomy. Right cyst of epididymis. Left hydrocele. Excised.
CHARITY 20. Epithelioma vagina.
21. Irreducible inguinal hernia.
Cot D. Nævus on face.

Solution to Case for Diagnosis.

(IN LAST ISSUE.)

Post-mortem there were found hæmorrhages into the lung substance and beneath the pericardium; and also into the substance of the spleen. The heart, kidneys and liver were normal.

The jejunum was rather dilated and showed some superficial ulcers in the mucous membrane. In the lower part of the intestine, especially in the cæcum and first part of the colon, were a large number of ulcers with irregular but not undermined edges, containing islets of mucous membrane, and extending right through to the peritoneal coat. Several of these had perforated and then become adherent. There was purulent peritonitis.

The spinal cord appeared very irregular on the surface, but showed no naked-eye changes. There was softening at the junction of the cervical and dorsal regions.

The question arises whether the case may have been one of typhoid complicated by myelitis, or, again, a primary myelitis with trophic ulcers of the intestine. The hæmorrhages would seem to point to a condition of toxæmia.

A Case of Henoch's Purpura.

By C. T. B. MAISEY, M.R.C.S., L.R.C.P. Lond.

J. M., æt. 8 years, was brought by his mother to see me on April 11th, on account of some spots appearing on his legs and arms. I examined him and found that he had an ordinary purpuric rash on his extremities, with a few spots on his chest, otherwise he appeared fairly healthy. No history of rheumatism in the family. I advised his removal to bed, milk diet, with some raw meat and orange-juice, and prescribed a mixture containing dilute Hydrochloric Acid and Perchloride of Iron. He progressed favourably, the rash rapidly disappearing. On the sixth day the mother called to tell me that her son had been in terrible agony with pain in stomach, and had vomited a bilious fluid; the pain, which returned at irregular intervals, was so violent that she could not hold him in bed. I visited him, but unfortunately an attack was not on. I carefully examined the abdomen for tumour, appendicitis and all the usual abdominal troubles, but with a negative result. The bowels had acted naturally, and the urine was normal. I prescribed a mixture of Bismuth. Salicylas with Opium, hoping to relieve the little patient, but the mother called again in the evening to report a

very bad day, the pain attacks recurring as often and as severe, and that the bowels had acted naturally, but the motion contained a little mucus and blood. I increased the opium, but with negative result. At my visit that morning the same report. Terrible attack of pain, no sleep. I again carefully examined abdomen and found tenderness over epigastrium and descending colon; per rectum no tumour or abnormality to be felt, but the bowel contained a little fluid blood and mucus. I asked my partner, Dr. Rust, to kindly examine the abdomen, and he did so with same result. The opium was increased to seven minims every hour. With this dose the sufferer managed to get some relief, the attacks of pain were less severe and at longer intervals. The bleeding from the bowel lasted three days. At the end of the second week of his illness he appeared to be progressing satisfactorily. On the 26th he complained of pains in his knees, ankles, wrists and elbow. All these joints were swollen, and the next day a purpuric rash appeared over them. This condition lasted three days, then his severe gastric pain returned with all its vigour, accompanied this time by bleeding from his urinary system, the urine being bright red with blood, and contained a few casts.

I strongly advised his removal to hospital as his nursing and surroundings were not of the best. He has now been an inmate at a children's hospital for five weeks, and has had during his stay several attacks of severe colic, recurrent bleeding from bowels, kidney, and swelling of joints. He is at present progressing favourably. There seems very little to be done for these cases beyond rest in bed, light food, and relief of pain. Fortunately (according to Dr. Stephen Maczenzie, in Dr. Clifford Allbutt's System of Medicine, Vol. V.), most of these patients get well after an indefinite period of weeks or months, although one fatal case has been recorded by Silvermann, from perforated stomach.

Another danger is nephritis. The chief symptoms of this case were:—(1) "The awful colic." (2) Bleeding from various organs. (3) Rashes and swelling of joints. (4) Tenderness over colon. The vomiting in this case was not so severe as in other reported case. I have reported this case on account of its rarity.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The late B. F. Henry.

DEAR SIR,—Permit me on behalf of my family to express our very sincere appreciation of the kind sympathy shown by so many of my son Franklin's friends at Guy's, in sending so beautiful a floral tribute to his memory. This testimony to his popularity has deeply touched us, and it is a great comfort to us in our heavy bereavement. —Believe me, dear Sir, yours very faithfully,

GEO. HENRY.

The Briers, Silverhill Park, St. Leonards-on-Sea.
July 27th, 1899.

Dennis Adams, J.P., M.R.C.S. Eng.

(From *Cambridge Express*, 15th July, 1899.)

CAMBRIDGE has lost one of its most worthy citizens by the death of Mr. DENNIS ADAMS, which occurred at his residence, 30, Sydney Street, Cambridge, on Sunday evening last, at half-past eight. The deceased gentleman was born in the village of Over on the 1st of June, 1813, and was thus in the 87th year of his age. At an early age he was sent to school at the late Mr. Johnson's, Llandaff House, Regent Street, but the restrictions of a boarding school and its contrast to home life proved so uncongenial to the young pupil that his education was somewhat summarily transferred to private hands. He was afterwards articled to his brother, who was a surgeon in practice at St. Neots, and he went to Guy's Hospital to finish his medical training, and having passed his examination subsequently became a M.R.C.S. In 1839 he came to Cambridge, where he soon acquired a considerable practice—a practice which rapidly increased, particularly amongst members of the University, until 1861, the year H.R.H. the Prince of Wales was "up." It is not too much to say that there was no more popular man than "Dr. Adams" amongst the many generations of wealthy undergraduates which came to and left Cambridge between 1850 and 1880. Many were the anecdotes told by the genial doctor of his social experiences amongst undergraduate members of the University, both in the hunting field and around the social board, and his popularity was proved by the frequency of invitations he received to the best dinners of the day, and by the number of University clubs (some of them very exclusive) of which he was elected an honorary member. On the 1st of January, 1889, Mr. Adams completed his 50th year's residence and practice in Cambridge, and the interesting jubilee was celebrated by many of his friends by the presentation of some handsome pieces of silver, accompanied by an elaborately illuminated address on vellum, tendering hearty congratulations, and alluding to the doctor's professional skill, genial company in the hunting field, and his generous hospitality. This address bore the names of hundreds of the doctor's friends, amongst whom were H.R.H. the Prince of Wales, Sir Charles Hall, Q.C., M.P., the Duke and Duchess of Manchester, Lord Huntly, and others.

As an enthusiastic sportsman, and one who had, perhaps, hunted with more packs of hounds than any man in England, it is not surprising to know that Mr. Adams was also a great lover of animals—indeed, his care for his horses was most touching. He spoke of and treated them as if they were his friends rather than his beasts of burden, and nothing more quickly incurred his anger than to hear of some unkind or inconsiderate treatment of his favourites by those whose duty it was to look after them. Few could surpass the deceased gentleman as a host, affable to all, carefully studying the tastes of his guests, and with an oldfashioned

courtesy which charmed all whom he delighted to entertain; but whilst he was an aristocrat and a gentleman to the backbone (indeed, *because* of this), he was ever mindful of the needs of the poor, to the supply of which he was an ever ready and generous contributor. On occasion, too, his generosity could not be confined to ordinary giving. Notable illustrations of this were afforded at the time of the marriage of the Duke of York and during the preparations for the celebration of Her Majesty's Great Jubilee; when the subscriptions towards a dinner for the aged poor appearing to be coming in rather slowly, Mr. Adams generously offered one hundred guineas to the fund, and thus made it one of the most popular features of the local celebrations in 1897.

Mr. Adams was one of the original founders of the Royal Albert Benevolent Society's Asylum for Decayed Tradesmen. *Dum Vivimus Vivamus* was his motto, and whilst fully appreciating the good things of this life himself, he took care that as many others as possible should rejoice with him when occasion offered. Speaking from the Borough Bench of Magistrates on Monday last, Mr. C. J. Clay took timely occasion, whilst lamenting the death of his senior resident colleague, to remind the world that Mr. Dennis Adams, amidst a busy professional life, found time to discharge important public duties. In 1868 he entered the Town Council as one of the representatives of the Market Ward, and continued in that capacity until November, 1877, when he retired. During his membership of the Council, after being present at a fire in Rose Crescent, he brought before the Council the desirability of forming a Fire Brigade. Mr. Thos. Nichols, the late Mr. Henry Hall, and the late Mr. Charles Wisbey were associated with Mr. Adams in starting the Cambridge Volunteer Fire Brigade. In 1866 he became one of Her Majesty's Justices of the Peace for the Borough, and for many years was a familiar personage on the Bench. He was one of the first County Aldermen, and in many ways identified himself with the life of the county. In 1890 Mr. Dennis Adams succeeded the late Master of Sidney (Rev. Dr. Phelps) as chairman of the Cambridge University and Town Gas Light Company, which position he occupied until February, 1898, when failing health compelled him to resign. From 1855 till 1895 Mr. Adams was a director of the Cambridge University and Town Water Works Company, and always took the keenest interest in the direction of its business. He was Vice-Chairman of the Company for six years, and one of the engines at the Fulbourn Pumping Station bears his name, being started to work on the 25th of March, 1891. He was also a promotor of the Trowbridge Water Works Company, and was, in the Act, named as one of the First Directors. He was elected Chairman in the year 1882, and remained Chairman up to the hour of his decease. He was also for many years surgeon to the Duke of Manchester's Light Horse, and was awarded the medal for long service, of which he was justly proud. The deceased gentleman was a widower, having lost his wife in 1853.

For several years Mr. Dennis Adams has been failing in health, but his wonderful vitality kept him about almost till the end. About a month ago, however, he became too feeble to rise, but his brain remained active until the last. Mr. George Wallis, M.R.C.S., and Professor Clifford Allbutt have been unremitting in their attendance upon their venerable colleague during his last illness. In politics he was a Tory of the old school, and, as Mr. Clay appropriately remarked from the Bench on Monday, "Dr. Adams was a warm friend and a generous opponent." His activity as President of the Conservative Association of Village Clubs in the Western Division of Cambridgeshire, will be remembered by many who were then associated with him, and the Conservative Party in Cambridge may well mourn the loss of a staunch friend. Although possessing no children of his own, Mr. Adams was very fond of the little ones, and it was his annual custom to send presents for distribution at Christmas time amongst the children who attended the annual children's party given in connection with the Beaconsfield Club.

It is well known to many of the deceased's personal friends that he had a personal objection to the modern practice of wreath-sending, but he had a still greater objection to thwarting the natural desire of those who wished in their own way to evince their respect for the memory of a friend. His Executors have, therefore, wisely abstained from the expression of any opinion upon the subject, leaving everyone to do as he or she thought fit. We happen to know of several instances where intimate friends of the deceased have sent the contributions which they would have spent upon a wreath to the Matron of Addenbrooke's Hospital, with a request that she would apply the amount in any way she may deem desirable for the benefit or relief of the sick poor.

Guy's Hospital Debating Society.

THE Annual Dinner of this Society was held in the College Library on Saturday, July 15th. The chair was taken by Dr. BRYANT, who was supported at the cross table by Dr. Spriggs, Mr. W. C. C. Pakes, Mr. R. T. Fitzhugh and Mr. F. Shufflebotham (Hon. Sec.). A good company was present, the Residents being represented by Messrs. C. Jephcott, K. B. Alexander, F. E. Walker, R. J. Swan, P. Turner and T. P. Berry, and the Clinicals by Messrs. A. E. Clarke, A. A. Miller, D. P. Watson and F. O. Stoehr.

After dinner only two toasts were proposed, the rest of the evening being given up to an impromptu debate.

The CHAIRMAN proposed "The Queen, Prince of Wales, and other Members of the Royal Family."

Mr. W. C. C. Pakes proposed "The Chairman," and in reply,

Dr. BRYANT said that he regarded the Debating Society as a very important institution at the Hospital, and was pleased that it received so much support. Mr. Shufflebotham had told him that the average attendance at the

meetings, including Ladies' Night, was 80. He wished the Society every success in the future, and promised to help it in every way he could.

Notices.

APPOINTMENTS, 1899—1900.

ASSISTANT DEMONSTRATORS OF ANATOMY.—Messrs. J. T. Hicks, C. H. Robertson.

ASSISTANT DEMONSTRATORS OF CHEMISTRY.—Messrs. H. H. Carter, E. H. B. Milsom.

ASSISTANT DEMONSTRATOR OF BIOLOGY.—Mr. N. Ivens Spriggs.

PROSECTORS.—Mr. Lucas (Oct., Nov. and Dec.)—Messrs. P. R. Bolus, W. F. Box, P. A. Peall; (Jan., Feb. and March)—Messrs. H. S. Brown, C. D. Pye-Smith, A. M. Webber. Mr. Lane (Oct., Nov. and Dec.)—L. S. H. Glanville, R. Larkin, H. C. Winckworth; (Jan., Feb. and March)—E. J. Gaffney, L. H. Moiser, F. Rogerson.

Guy's Hospital, July 15th, 1899.

GUY'S HOSPITAL MEDICAL SCHOOL.

Applications are invited for the vacant post of Demonstrator of Chemistry and Physics, and should be sent to the Treasurer, Superintendent's Office, Guy's Hospital, on or before July 31st.

Particulars of duties, which will begin on October 1st, may be obtained on application to the Dean.

Guy's Hospital, July 24th, 1899.

GUY'S HOSPITAL MEDICAL SCHOOL.

Applications are invited for the vacant posts of—

(1.) Lecturer on Biology,

(2.) Anæsthetist in the Dental Department,

and should be sent to the Treasurer, Superintendent's Office, Guy's Hospital, on or before September 1st.

Particulars of duties, which will begin on October 1st, may be obtained on application to the Dean.

Guy's Hospital, July 25th, 1899.

Papers by Guy's Men.

Two Further Instances of Extra-uterine (one Tubal and one Ovarian) Gestation in which Rupture occurred before the end of the First Month. Operations. By Gilford Hastings, F.R.C.S. (Illustrated).—*Lancet*, 24th June.

Non-fatal Perforation in a case of Gastric Ulcer; Hæmatemesis; Transfusion. By C. J. Whitby, M.D.—*Ibid.*

The Pathology of Pyrexia. By W. Hale White, M.D., F.R.C.P.—*Clinical Journal*, 21st June.

The Principles that should guide us in the Treatment of Tubercular Disease of the Hip-joint. By W. Arbuthnot Lane, M.S.—*Ibid.*

Nursing Notes.

IT seems to me we do nothing but record a series of successful entertainments in this column. The last and the largest took place at Marlborough House. Perhaps it would be better to designate it as a function, for it was a very important one, at least for the nurses. Unfortunately the *Telegraph*, the *Chronicle*, and other papers have been first in the field with their reports, leaving little for us to say; moreover, every detail has been discussed by the nurses themselves from beginning to end.

The agitating question before going was what style of obeisance should be presented to the Princess. Curtsies, bobs, and bows were practised beforehand with startling results. Much information was gleaned from one nurse, who had a friend, who in her turn had a friend who was once presented unofficially to Royalty, but it turned out to be German Royalty, at which there was a distinct feeling of unreliability, and it was decided that no practical use could be put to such second-hand knowledge.

The only part of the drill carried out really smartly was when the order was given, "March past for drinks."

We hope to see more of our nurses wearing the armlet next time. We do not think the benefits of this pension fund are properly appreciated and understood. Those of you who have indistinct ideas that the contribution of half your income in youth will bring in the handsome annuity of £7 10s. a year in old age should go and learn truth from someone with a clear brain and lucid understanding. I write feelingly, only having been recently enlightened myself.

We want to know what has happened to the old Colonnade stones? Someone said they were to be sold for a shilling each. If so we should like to buy a few as mementos; the awkward question would be where to put them. Superfluous furniture is not allowed in the cubicles, and we are sure the dustmen who move our trunks when necessary would object to moving paving stones. Our humble suggestion is that they should form a pathway to the nursery, and thus

"Hold it truth with him who sings
To one clear harp in divers tones,
That Pros. may walk on paving stones
From the nursery till they get their strings."

"L'INCONNUE."

Passim.

The holidays have again come round, and our senior staff have mostly disappeared to enjoy the pleasures of seaside or country for a season. Lectures have ceased, and the first and second years' men (lucky beggars) have left their accustomed haunts for more salubrious airs. Yes, we do envy them, and at the same time bewail the hard fate that compels us to take up the editorial pen with the thermometer standing at 80 in the shade. At the same time we exhort them to make the very best of what we hope is a well-earned rest—possibly the last real holiday they will be able to spend for some years to come.

And let them think at times of their friends up at Guy's, for there is, of course, no appreciable dimunition in the flow of patients into the front surgery. The assistant surgeons are perhaps the hardest-worked individuals at the present time, the work of three or more often falling to one. But, as usual, it is an ill wind, etc., etc., and the increased responsibility for H.S.'s, H.P.'s, and dressers, is fully appreciated by them at any rate.

It is with very deep regret that we record the terribly sudden death of B. F. Henry, at the Southwark Baths, last Wednesday week. He was apparently in the best of health, but was seized with an attack of cramp or syncope while swimming, and though taken quickly from the water, all efforts to restore animation proved futile. He was a student of our dental school and a thorough sportsman. Besides being an accomplished swimmer and gymnast, he was a keen member of the cycling club, and many will recall his exceptionally plucky riding at the Inter-Hospital Cycling Competition two years ago, when, after a heavy fall in the twenty-mile race, he remounted and finished the full distance, thus enabling Guy's to retain the shield which otherwise they would have lost. Those who knew him all testify to his excellent qualities, and the beautiful wreath sent to Ore Cemetery, Hastings, where he was laid to rest last Monday, was but a slight token of the esteem in which he was held by his fellow-students. His relatives have our very deepest sympathy in their sad bereavement.

The first of Mr. and Mrs. Bonsor's garden parties, to which they had so kindly invited our Nursing Staff, the Residents, and others, passed off in highly successful fashion last Wednesday. The weather was perfect, and with such a host and hostess it is needless to say that nothing whatever was left undone which could add to the pleasure and enjoyment of their guests. Those whom the spirit moved indulged in lawn tennis, croquet, and other pastimes, while their less energetic brethren and sisters strolled round the beautiful grounds to the music of a first-class band. We must put down yet another item to the already large debt of gratitude which we owe to our kindly Treasurer and his charming wife.

Mr. Rowlett will, we hope, excuse our publishing his letter to us in our "Lighter Vein" column, as it seems only fair that the writer of the words which have been called in question should have the opportunity of explaining that the meaning he intended to convey was quite different to the construction put upon the words by our correspondent. No one for one moment would deny that among the dental students there are many excellent athletes, and again, we believe no one who has been any length of time at Guy's would deny that the wearing of Guy's colours in hatbands and neckties, is far more popular with the dental students than with the medical. Hence the confusion which certainly has arisen.

By the death of Mr. Dennis Adams, for many years the senior resident Justice for the Borough of Cambridge, Guy's loses its oldest living son. Born in 1813, he qualified at this hospital, and then practised for upwards of fifty years in Cambridge town. His death at the ripe old age of eighty-six was not unexpected, as he had been in declining health for some years past. In another column we publish a fuller notice of this worthy offspring of our hospital—an enthusiastic sportsman, a highly-respected practitioner, and a thorough gentleman.

A most appreciative article—though to us at Guy's quite unnecessary—of the work of our nurses who went out to Greece in 1897, appears in the current issue of the *Nursing Record*.

The work of re-building, or rather transplanting the Hospital Laundry is now in full swing, and the temporary engines can now be seen sweating and fuming in the open space

till recently monopolised by the players of stump cricket. It seems a great pity that this pastime should be permanently suspended, but unless the authorities provide another eligible site, we fear that the healthy whizz of the tennis ball will not be heard again.

THE Guy's cricket season, which started with much promise, was brought to a somewhat disappointing close last Saturday, when the first team were defeated by Brentwood by 31 runs. At one time we seemed to have the making of an excellent all-round team, but unfortunately our bowling did not develope to the same extent as did our batting, and when thoroughly tested was, alas, usually found wanting. However, there is the hope—fairly certain in this case—that next season, with practically the same team again available, we shall have a considerably better chance of regaining the Cup, which until recent years was always regarded as our especial property.

THE United-Hospitals' Team that visited Dublin and competed against Trinity College, last Tuesday, hardly met with the success that the long journey deserved. Leggatt won both jumps, and Graham the half-mile, but all the other events went to Dublin. Leggatt nearly succeeded in winning the hurdles, but fell at the last obstacle when leading by fully two yards—a piece of very bad luck.

On the Decline of Scurvy.

(Being a Paper read before the Hongkong Branch of the British Medical Association, February, 1899, by Surgeon C. MARSH BEADNELL, R.N.

MR. PRESIDENT AND GENTLEMEN,—I have been asked by your Secretary to read a paper upon some medical topic pertaining in a greater or lesser degree to the Navy.

It would be a superfluity on my part to tell you that the malady which is uppermost in the minds of naval and military surgeons of the present day is venereal disease. This, however, is not the subject I have selected, having deliberately fixed my choice upon a malady to which medical men of to-day seldom give more than a passing thought (and that for obvious reasons), a malady which, however, made our medical predecessors of but a few years back stand aghast at its ravages. I allude to Scurvy.

I trust you will forgive my presumption for monopolizing your valuable time with a paper upon a disease happily well-nigh extinct, at any rate afloat; the only excuse I am able to offer you is that I think it is beneficial to ourselves and certainly only just to the physicians and surgeons of the past to occasionally shade our eyes and look back into the times that have been in order that we of to-day may duly perceive and appreciate the inestimable benefits relegated to us by those of yesterday. I can call to mind no malady that has wrought so much havoc amongst the toilers of the deep in past years as scurvy. It is impossible to avoid commiserating with Jack Tar after reading Cowper's vivid description:

'The mariner, his blood inflamed
With acrid salts, his every heart athirst
To gaze at nature in her green array;
Upon the ship's tall sides he stands, possessed
With visions prompted by intense desire;
Fair fields appear below, such as he left,
Far distant, such as he would die to find.'

Fortunately, however, for us naval surgeons, our medical predecessors have handed down to us not only the preventive treatment, but also a specific cure for this disease.

About a year ago some of you may have read in the *United Service Magazine* an article entitled "Lime Juice; Some Centennial Remarks," by Commander Galloway, R.N. Though written by a non-medical man, the article in question was replete with interest to all, but in a paramount degree to the medical branches of Her Majesty's Services. The perusal of this paper had the effect of stimulating me into searching all the medical periodicals I could lay hands on with a view to forming an estimate of and comparing the amount of mischief caused by scurvy in bygone days with that existing at the present time. The result of this quest I desire to put before the meeting this evening.

Scurvy, or, as it is technically called, *Scorbutus*, is a Latinized word derived from the German *Scharbock*—itself derived from the Danish *Skörbeck*, signifying "disease of the mouth." The disease is, or perhaps one should say *was* essentially of a cosmopolitan order, and has in every probability been existent since that period of yore when our prehistoric simian-like ancestors climbed down from their arboreal dwellings and took to terrestrial quarters *pari passu* renouncing a diet hitherto mainly frugivorous for one more carneous; in other words, scurvy has in all likelihood exercised its malign prerogative over the human species since the dim and distant dawn of civilization.

It, of course, goes without saying that the earliest descriptions of this disease emanated about 400 B.C. from the pen of Hippocrates, for surely this was the dire infirmity the Father of medicine had in his mind when he wrote of "a condition marked by foul breath, gums receding from the teeth, bleeding from the nose, and ulcers of the legs." Scurvy in the olden days was plague-like in character, assuming occasionally the form of a pestilence both epidemic and pandemic. It prevailed extensively during the Crusades; an epidemic of it occurred about 1218 A.D. at the siege of Damietta or Damyat (more anciently called Tamiathis), a town on the banks of a branch of the Nile. In 1486 an epidemic

occurred in Germany at the time of the wars of Ferdinand II. with the Saracens. In the crusade of Louis IX. against the Saracens of Egypt, the French army suffered greatly from it at Cairo. In the sixteenth century it prevailed endemically all over the north of Europe; in badly-fed armies, in besieged cities, and on board ship its ravages were described as simply appalling—it is a signal fact that more seamen perished from Scurvy alone than from all other causes combined, whether sickness, tempest or battle.

Scurvy is produced by the consumption of foods deficient in certain organic salts, notably the Potassium salts of the vegetable acids, those more commonly met with being the malates, citrates, lactates, and tartrates of the metalloid: I advisedly make use of the words "consumption of foods," notwithstanding the popular and widespread, but nevertheless erroneous idea, that this is a malady of the poor and starving; it certainly may, in fact usually does occur in those on a parsimonious bill of fare, but *the* 'sine qua non' is inappropriate food, not insufficient food—let the gourmant glut himself with comestibles lacking the above-mentioned salts and he will, sooner or later, almost assuredly contract scurvy, glut he never so voluptuously; on the other hand, withhold all food from him, let the negation of nourishment be absolute and scurvy will not manifest itself. You have all heard of the Welsh fasting girl, and the American professional faster Tanner; some of you even may have seen the Italian, Giovanni Succi, exhibited at the Royal Aquarium, London, a few years back, for the edification of a morbid section of the public. He was supposed to live on water for forty days and forty nights, but the number of these hysterical voluntary victims of starvation is legion, yet none of them, so far as I am aware, has been known to contract scurvy whilst undergoing his or her self-enforced term of xerophagy.

To revert to our vegetable salts; there has been much dispute as to whether it is the basylous or acidulous radical of the salt that possesses the anti-scorbutic properties, it is more than probable that the specific is to be found in neither 'per se' but rather in the combination of the two. Citric acid is valueless in scurvy, so also is Potash, but Citrate of Potassium we know to be invaluable in this disease. Of the two radicals, however, the basylous seems to play by far the more important rôle. If we take a series of well-known anti-scorbutic remedies we invariably find Potassium present in the base of the salt to which the remedy owes its medicinal value, but the acid varies considerably, thus in lemons, limes, oranges and tamarinds we find Potassium Citrate ($K_3C_6H_5O_7$), in the mountain ash, in apples, gooseberries, currants and strawberries, Potassium malate ($K_2C_4H_4O_5$), in rhubarb and cherries Hydro-Potassium malate ($KHC_4H_4O_5$). It has been said that tobacco-smoking will relieve scurvy, it is hard to see how this is so unless the smoker either 'chews' the tobacco, or, having finished his cigar or pipe, makes a meal of the ash—be this as it may, malates and citrates of Potassium are present in considerable quantities in the leaves of *Nicotiana Tabacum*. In meat is to be found Phosphate of Potassium ($KHPO_4$) and Sarcolactate of Potassium ($KC_3H_5O_3$); a salt isomeric with the latter is also to be found in milk and in willow leaves. Grapes we know used to be one of the most valuable remedies in scurvy, they owe their medicinal value to a Hydro-Potassium tartrate familiarly known to wine manufacturers as Argol or Cream of Tartar; I think you will agree with me that this salt affords a beautiful illustration of the absolute indispensability of the Potassium part of the salt, for by replacing it with Sodium we get the corresponding Sodium salt which is useless as an anti-scorbutic, and yet how similar are these two salts structurally and chemically:

Hydropotassium Tartrate ($KHC_4H_4O_6$).
Hydrosodium Tartrate ($NaHC_4H_4O_6$).

Why these two metalloids, Potassium and Sodium, so alike physically and chemically, should play such antithetical parts in the animal economy (and this peculiar behaviour is not confined to the animal kingdom, as I hope to show later) is a puzzle alike fascinating and perplexing. Why should Potassium be in the ascendant in the red blood corpuscles of the blood, and Sodium in the fluid part of it, and Potassium in the somatic cells outside the vessels? Why should the Gastrocnemius of a frog placed in a saucer containing a solution of Sodium Chloride beat rhythmically like heart muscle, and lie motionless in a corresponding solution of Potassium Chloride? Why should Potassium salts dialyze rapidly through animal membranes and Sodium salts but slowly? When Glauber immortalized his name in a hydragogue purgative he was unconsciously utilizing this fact when he chose Sodium Sulphate in preference to the Potassium salt.

One of the most remarkable differences in the behaviour of these two salts has been pointed out by Nothnagel in Virchow's Archives; he exposed the intestine of a frog and applied a Potassium salt to its external or peritoneal surface; a contraction of the gut immediately ensued, but this contraction was strictly localized to the point of contact and did not spread beyond it; he then made a similar experiment with a Sodium salt and to his astonishment found that a contraction of the gut ensued which was not limited to the point of contact, the contractile waves spreading towards the pylorus and away from the anus.

Lastly, why should Potassium when in conjunction with a vegetable acid alleviate scurvy, whilst the exhibition of Sodium only results in the aggravation of the disease? We do not know, but it is more than probable that, if ever discovered, the key to the mystery will be found to bear a very close relation to the above-mentioned curious distribution of Potassium and Sodium in the animal organism.

The human form divine is an entity exceedingly intolerant of anything approaching a deviation from the normal—it must and will have its *correct* 'quantum' of Potassium: stint it by eschewing vegetables, it manifests its displeasure by breaking out into scorbutic sores;

overdose it (as do all vegetarians), it succumbs to mental and physical inertia.

Lauder Brunton holds himself aloof from the theory that scurvy is due to a deficiency of Potassium salts in the blood; he thinks it more probable that the real cause of the disease is an excess of chlorides either absolutely or relatively to the carbonates. Potassium salts alone, he says, do not cure scurvy, neither does beef-tea, which contains them. He alludes to the fact that if the mesentery of the rabbit, or web of the frog be placed under the microscope, a rapid and violent diapedesis of the red blood corpuscles occurs as an immediate sequence to the injection of Sodium Chloride into the blood.

When a person commanding so great a respect in the pharmacological world as does Lauder Brunton fosters any theory, it is a difficult matter and takes a brave man to atttempt a dislodgment of that theory. Certainly the injection of Sodium Chloride into the blood seems to bring about many of the pathological changes incident to scurvy—such as the diminution of the red blood discs, and hæmorrhages subcutaneous, subperiosteal and petechial, but at the same time may not the real cause be the scarcity of Potassium? May we not look upon the Sodium entering the sacred domains of the blood-vessels and causing the rapid disappearance of the blood discs, together with the valuable Potassium they contain, in the same light as a man-eating tiger suddenly let loose upon a native village causing the inmates to efface themselves with the utmost celerity, throwing for the nonce the utilitarianism of the community completely out of gear? I think Brunton overlooks (when speaking of scurvy) the remarkable fact to which he draws attention in another part of his work,* that an increased ingestion of Sodium Chloride not only causes an increased egestion of it (viz. Sodium) and of urea by the kidneys, but at the same time brings about an increase in the egestion of *Potassium* salts by those channels.

There are several predisposing or auxiliary causes of scurvy, the more important of which are inappropriate food, foul and re-breathed air, mental depression and physical exertion prolonged to an abnormal degree.

The two last causes in combination are specially prone to invite the onset of this disease; imagine, for example, two armies, each subjected to the same environments, hardships, and fatigations which we know to be inseparable from active service, but the one victor and the other vanquished, that one more liable to contract scurvy is the latter, for to the other adverse circumstances would be the superposition of mental depression, whereas the former would be buoyed up by that most potent of prophylactics—mental elation, one of the physiological concomitants of success.

Whether the consumption of abnormal food is intrinsically a direct or merely a predisposing cause of scurvy, is a question still open to discussion, for just as a vitiated atmosphere from overcrowding and foul drains, etc., is but a predisposing cause of such diseases as enterica and diphtheria, the immediate and primary cause being a *contagium vivum* without which all predisposing causes are null and void, so may inappropriate nourishment be but one of the auxiliary causes of scorbutus, the *fons et origo* of the malady being a specific micro-organism. That this is no chimeral speculation is proved by the researches of Frerichs and Frein, and other pathologists; certain micro-organisms of the bacilli variety were obtained from the gums of scorbutic patients, which structures, as is well-known, become loose, spongy and tender, recede from the teeth, and bleed freely on the slightest provocation (though, as in lead poisoning, in edentulous subjects the gums escape); these bacilli were sown and cultivated upon various nutrient media for several generations, and cultures of the third, fourth, and even later generations inoculated into guinea-pigs and dogs gave rise to the characteristic gingival affections, capillary hæmorrhages, bone lesions, etc., seen in inveterate cases of scurvy; again, purpura hæmorrhagica, a very allied disorder, is now known to be always associated with a bacillus discovered by Lizzoni and Giovannini, in 1889, and independently by Babes, in 1890, and Kolb, in 1891. It is a well-known fact that a scorbutic mother will transmit the disease to her child (if she suckles it), but this, of course, proves little or nothing; it may mean the transmission of the microbe *in utero*,' as obtains in syphilis, or by the milk; or on the other hand it may simply mean that the milk is itself deficient in antiscorbutic salts. The latter is the more probable state of affairs, as children brought up on hay-fed (London) cows frequently fall victims to scurvy. Dr. Buzzard, in Reynolds' system of medicine, seems at times to look favourably upon the microbial theory of the disease; he lays stress upon the fact that it occurs in outbreaks; he himself witnessed the ravages of scurvy amongst the allied troops in the Crimea, where there were 23,000 cases in the French army alone; he shows how climate, overcrowding, squalor, starvation, bad meat, and salt food cannot individually or collectively produce this disease.

Cases of maritime scurvy have become very infrequent of late years, so much so indeed that I do not hesitate in saying that few naval surgeons have seen a case, but it must not be imagined that there is a similar declension in numbers of all the varieties of this disease: Infantile scurvy, so called, is alarmingly on the increase. (Here let me say that infantile, land, and maritime scurvy are but variform appellations for the same malady occurring in diverse individuals under different conditions of environment; in their symptoms, causation, and treatment, they differ in no material respect). Möller, in Germany, and Smith, Cheadle, and Barlow, in our own country, especially the latter in his Bradshaw lecture in 1894, have drawn attention to the increasing frequency of infantile scurvy; at first this disease was diagnosed as some aberrant variety of rickets, then as a hybrid disease or cross between rickets and scurvy, but the above observers have now proved it to be true scurvy, the same disease that so harassed our sailors in times past. The

* Pharmacology, Therapeutics and Materia Medica. By T. Lauder Brunton, London, 1893.

symptoms more or less peculiar to the infantile variety of the disease are, subperiosteal hæmorrhages, especially in connection with the femora, whereby the infant is rendered pseudoparalytic, a slight rise of temperature, seldom above 101·5° F., spongy gums, purpura, hæmaturia, and a condition of leucocythæmia, and, if the disease remains untreated, subconjunctival and retinal hæmorrhages and anæmia, and rapid emaciation, usher in death.

It is not necessary to seek far for the reason of this serious increment amongst children. Remembering that one of the primary factors in the production of scurvy is the consumption of foods deficient in certain organic salts, which collectively may be termed antiscorbutic salts, compare the nourishment of the present day infant with that of his forefather, say, a couple of generations ago, who came into the world and obtained his sustenance from his maternal parent after the manner that nature has ordained; not so the modern infant—the helpless victim of latter-end nineteenth-century tight-lacing fashion is not to be naturally nourished by her who bore him, but artificially by one or other of the multitudinous proprietary infant foods that now flood the market and gorge the advertisement spaces of railway stations and society journals. It is the wealthy classes who are the chief sinners in this respect, the habit being based upon the erroneous but deep-rooted belief that by the avoidance of suckling one's offspring the slim and comely form of maidenhood will be the longer retained, and that great bug-bear of the gentler sex, the 'passée' state, for a while postponed; the poorer classes, on the other hand, have neither the time to devote to the study of callaesthetics, nor yet the wherewithal to purchase artificial foods for their infants, they must perforce use nature's fount; hence the comparative rarity of the disease amongst children of the poor and its increasing frequency amongst those more comfortably situated. Barlow in his Bradshaw lecture states, 'Proprietary foods are the great offenders, condensed milk is responsible for a fair number.' He again says 'in no single case of scurvy at the time of onset has the child been breast-fed.' The disease has been known to occur as early as four months and is not unknown between nine and eighteen months of age. In the *New York Medical Journal* for May 26, 1894, Messrs. Northrup and Crandall publish an interesting study of a series of thirty-six cases of scurvy in young children. Most of their cases were met with in private, not hospital practice, before the eruption of the teeth gum symptoms were absent.

Citrates have been used empirically in scurvy for centuries. The beneficial effects of the *Citronaceæ* in scurvy were known to the Dutch seamen who traded to Spain in the fourteenth century and availed themselves of the necessary remedies out of their cargoes. In a pamphlet called 'The Surgeons' Mate and Military Adviser,' written by one John Woodall, Master of Chirurgery, and published in 1617, it is stated that 'The lemmons, limes, tamarinds, and oranges and choyce of good helpes in the Indies which you shall find there, do far exceed any that can be carried thither from England, the use of the juice of lemmons is a precious medicine and well tried.' In 1573, Salomon Albertus is mentioned as having employed lime-juice in cases of scurvy, and in 1593 Sir Richard Hawkins is recorded as having administered it to those suffering from that disease, but it was not till 1795, that, owing to the repeated exhortations of Sir Gilbert Blane, —a name familiar to every naval surgeon—the Admiralty condescended to issue an order to the effect that lime-juice was to be regularly furnished to His Majesty's ships of the royal navy. This very remarkable condescension on the part of the Admiralty was due to the fact that that august body had (fortunately for long-suffering Jack) completely lost its head, being panic-stricken by the prevalence of the disease in that part of the fleet then under Lord Howe, rendering it, in so far as its belligerent ability was concerned, a negligible quantity; the advice tendered to them year after year by Gilbert Blane only to be spurned was now as eagerly clutched at as a straw by a drowning man: whether in the future the Admiralty had cause to regret their acceptance of Sir Gilbert Blane's advice I shall leave to your own judgment, having first invited your consideration of the following cardinal figures: in the year 1780 the number of scurvy cases admitted into the Naval Hospital, Haslar, was 1457, in 1806 but one case was admitted, and in 1807, one case. Article 1735 Queen's Regulations, 1893, now reads 'On the requisition of the medical officer, lime-juice and sugar in quantities not exceeding half-an-ounce of each per individual per diem are to be issued to every person on board as the captain may direct.' The first naval surgeon, however, to draw attention to the fearful ravages amongst sailors committed by scurvy was not Dr. Blane but Dr. James Lind, physician to His Majesty's Royal Naval Hospital at Haslar; this was in 1753.

Here it may not be irrelevant to say a few words concerning the remedy for this disease. 'Lime-Juice' is the juice expressed from the ripe fruit of *Citrus Limetta*; the liquid should have a Sp. Gr. = 1037, and contain 32·2 grains of citric acid per fluid ounce, the acid occurring both free and as the potassium salt, it is to the latter that the lime juice especially owes its antiscorbutic properties. The effect upon the blood of taking lime-juice is to render that medium more alkaline,* the potassium citrate being oxidized into alkaline potassic carbonate which remains in the blood, and carbonic acid which is removed by the lungs as water and carbon dioxide, thus:

$$2\,(K_3C_6H_5O_7) + 4\,H_2O + 9O_2 = 3K_2CO_3 + 9H_2CO_3.$$

There are several varieties of lemon, lime and even tamarind juice on the market (the pulp of *Tamarindus indica* contains from 1 to 12 per cent. of citric acid). Concentrated lemon juice is exported from Sicily, concentrated Bergamot juice (*Citrus Bergamia*) from the Calabrian coast of South Italy, concentrated lime juice from the West Indies. The official lemon juice (*Limonis Succus B.P.*) has a sp. gr. of 1035 to 1045, and contains thirty-six to forty-six grains of citric acid in one fluid

* That is in good lime-juice where there is not too much free acid.

ounce. Lime-juice as imported into England contains an average of 7·84 per cent. of citric acid, if free from sugar and mucilage it requires no addition of spirit to preserve it. Lemon-juice, however, requires 40 per cent. of proof spirit to prevent fermentation, and as commercial lime juices are often sweetened with sugar, the addition of alcohol is found necessary, about one ounce of Brandy, to which the juice owes its colour, being added to every ten ounces of the juice; in lieu of adding alcohol the juice is sometimes boiled, this latter method, however, is far less efficacious, and, in cold climates almost useless, for whereas the unfortified juice freezes at—4°C., that containing spirit does not congeal till a temperature of—9°C. is reached, a detail of no small account to a North Pole expeditioner. Parkes recommends the addition of Glycerine to prevent freezing. The impurities to be reckoned with in lemon and lime juices are sulphuric and hydrochloric acids; the amount of these mineral acids may be ascertained volumetrically by adding a known quantity of soda, evaporating to dryness, incinerating, dissolving in water, then adding a known quantity of acid to estimate the quantity of soda still remaining free; the soda lost indicates the amount of free mineral acid.

(*To be continued.*)

In Lighter Vein.

THE Debating Society Dinner was, as I predicted, a very cheerful function. Dr. Bryant took the chair and kept everyone well supplied with subjects for discussion and food for thought, and other kinds of nourishment. There was much wit and no wisdom; consequently the success of the evening was never in doubt.

A patient in the Surgery, one night last week, said that he had been told he was suffering from a "prehistoric brewery." There are witnesses to prove this statement. Thus may Fiction after many years become Fact.

It is a great thing for a hospital patient to have aristocratic and influential friends; witness the following notes addressed respectively to "The Nurses in Charge of No. 3 Ward of Guy's Hostiple," and to "The Docter in Charge of No. 3 Ward of Gux Hositpitle"—

> "To the Nurse of No. 3 Ward will you give kind attention to your patient of the above in your usual kind manner to Archable R. Springhall he being away from kind Friend will need your especal care."
>
> "Mrs. Wagen's kind complements to the Dr. in charge of No. 3 Ward and hopes that what care and attention can be given by Drs. and Nurses will be given to Archable R. Springhall will be of the greatest care posible will you kindly state the next visiting hours."

The Lady enclosed her card.

The only other humorous letter I have to offer this week is this:—

To the Editor of the GUY'S HOSPITAL GAZETTE.

SIR,—In your issue of July 15th, I was somewhat surprised to read the following:—"At present it is impossible to tell whether a man is a Blue or Dentist."

What appears to be insinuated by these words is that a large number of the members of the Dental School are wearing Hospital Blues, and that without any right to do so. Such an insinuation, implying as it does an absence of sportsmen among the Dentals, is as objectionable as it is unwarranted. For though this would-be humorist may himself be but a poor sportsman—indeed one is strongly tempted to assume this to be the case—he must have seen by his own GAZETTE that not a few Dentals have won well-earned Blues, and that many others, although not Blues themselves, have helped to bring honour to the Hospital and trophies to the Smoke Room.

Besides the annoyance such remarks as his must cause these, and indeed all right-minded Guy's men, whether Medicals or Dentals, they are a danger to the good feeling existing between the two Schools. I do not know the name of the author of the statement referred to, I do not wish to know it; but, whoever he is, he would do well to learn that, though it may be good to know how to say smart things, it is sometimes better to know how not to say them.—I am, Sir, Yours very truly,

ALFRED E. ROWLETT.

Guy's Hospital,
July 21st, 1899.

Now, I have no compunction in contradicting Mr. Rowlett, as he evidently does not mind contradicting himself (cf. beginning of third sentence and the final aphorism). Really, I did not insinuate the terrible things Mr. Rowlett says I did. What I meant to imply was that to the casual observer the "Blue" hatband is not essentially different from the ribbon introduced by the Dental School some years ago and now extensively worn by the Dental men, and in a much lesser degree by Medical Students. The point I was trying to drive home was that there is no official Guy's ribbon; and further that there is nothing to prevent any Boro' publican from buying and wearing what usually passes as a Guy's hatband, and further still that nothing does prevent him.

It is my misfortune that I do not possess our correspondent's wealth of language to express myself, but I am far too used to being misunderstood to be disappointed. As to my having implied that there are no Dental sportsmen—the idea is absurd. Is there not Mr. Rowlett?

With regard to the statement that my poor remarks are "a danger to the good feeling, etc.,"

I can only thank Mr. Rowlett for the implied compliment; but I am sorry he thinks the said good feeling rests on so fragile a basis.

To save Mr. Rowlett all further trouble, I may as well say at once that his apologies are accepted.

HIGH-CLASS PROVERBS AT POPULAR PRICES.
(Fresh made for each customer.)

Too many cats spoil the meat-juice.

Half a loaf is better than no bread. This statement does not apply to diabetics.

Charity begins at home; but every other card usually goes round to the Institute.

Necessity is the mother of invention. A good many of her children have died in infancy.

You may lead a horse to the water, but it is ten to one the bath will not be in working order.

All men are liars. Hence it follows that truth is stranger than fiction.

Primary union is strength, but granulation is the thief of time.

A surgeon is not without honour—save in his colleague's estimation.

Truth lies hidden in a well. But it is frequently discovered at the post-mortem examination.

Though it may be good to know how to say smart things, it is sometimes better to know how not to say them.

And so much easier.

C. H. G. HOWLS.

Locum Tenens.

IT may not be amiss, now that the great holiday season has commenced, to make a few remarks, general and particular, concerning Locum Tenens; for most practitioners have to put up with them, and all "locums" have to put up with practitioners, and, what is more to the point, often have to put up with their wives, their cousins, and their aunts.

About this season, no two medical men meet together without discussing the vexed question—and when several assemble, as at a dinner, or other function, the conversation is usually sustained by anecdotes concerning these latest products of hospital education. Prices are quoted—the market is rising—and the young gentleman now demands four guineas instead of three, as formerly, for the privilege of being allowed to learn private practice, and in some cases private manners as well.

A friend of mine was particularly unfortunate for two seasons. One year the locum was addicted to morphia and forgot to book his visits, so his mind was a blank concerning them. The year following, the new locum had, on my friend's return, to be taken away to an asylum on an urgency order. This was a double stroke of bad luck. I, myself, had nearly as bad an experience. I got a very learned locum, specially recommended, who started, as soon as my back was turned, depopulating the town in which I practice. He found that the air, the water, or what not, did not suit certain of my patients, and I found on my return, that he had persuaded three to remove to a distance, while others had grown so discontented with a charming and healthy town that their exodus is only a matter of time.

One locum was a very strange fellow, and, as many of my readers know him, the following account will amuse them. My informant, a country doctor's wife, was greatly struck by his extraordinary tidiness. In his bedroom his sponge, tooth-brush, etc., were never left about, so that the servants naturally supposed that the tidy man put them away in his bag each time after using. However, when he went away, they found that this was not the case, for the groom confided to Betty Chambermaid: "Young Dr. ——— was a queer gent, he used to borrow my brush and comb and *tooth-brush* every morning!" They had the greatest difficulty in dissuading this same "locum" from preaching in the village Bethel!

Another locum, who might have been first cousin to the above, used always to smoke a pipe on his round and put it into the coachman's mouth, to keep it alight, each time he made a visit, after which he resumed his smoke!

Locums as a class consider it *infra dig.* to dispense medicines, which generally resolves itself into the fact, that they don't know how to do so. The bottles explode sometimes at the patient's bedside, or slip out of their wrappers in the boy's bag. The mixtures invariably taste nasty—at least, so the patients say.

One locum I had was admirable; he knew his work, did not eat with his knife, nor come to dinner with my family in carpet slippers. Nevertheless, the lady patients objected to him because "he was far too handsome." This was gratifying to me as I happen to be a plain man.

I will conclude my last words with a little scene between my last locum and a lady patient

SCENE.

(*Consulting room*, elegantly furnished, in good provincial town. Locum discovered seated in arm chair smoking, slippers, down at heels, on feet. Reads "Pink 'Un" and blows a cloud.) Bell rings.

Maid. "Lady Paywell, sir."

Lady P. "Oh! Is Doctor Dondib away? I am sorry. You're the locum, how do you do. I only called about my little girl" (pushes child, æt. 4½, forward).

Locum. "Hullo, what's up kiddie" (child gets behind Lady P., who seats herself). "Now, what's the matter with her?"

Lady P. "I don't exactly know——"

Locum. "Then what did you bring her here for?" (Lays down pipe.)

Lady P. "She doesn't quite seem herself, and I thought she needed a little medicine."

Locum. "Bowels open daily?"

Lady P. "Yes."

Locum. "Appetite good?"

Lady P. "Yes, very fair."

Locum. "Any pain?"

Lady P. "No."

Locum. "Any cough?"

Lady P. "No."

Locum. "Sleep well?"

Lady P., timidly. "Yes, but I thought if she had a little medicine——"

Locum. "I shant give her any; there is nothing the matter with her" (pushes child back, who commences howling). "Good morning" (rises, takes up pipe, which is still alight, and opens door of consulting room).

Lady P. (sotto voce). "Nasty horrid man!"

RONDIB.

Mainly about Nothing.

DESPITE the heat of the weather and the scarcity of ice, there have been a few events in the last fortnight sufficiently interesting to provoke a languid discussion among the loungers of the colonnade. It needs, however, but little to stir the souls of those weary watchers for the overdue; even the repetition of that dreary dirge, "Down the steps, fourth door on the left, and under the red lamp," elicits a brief reflex from nearest bystanders. It is little wonder then, that the elegant and tasteful barrier which the authorities have erected immediately opposite the front lodge should arouse the artistic to outspoken thought. Considerable difficulty has been experienced in exactly determining the school of architecture to which it belongs. The consensus of opinion allots it to the early stages of the classical revival, in the very early stages, before artificial respiration ceased, so to speak.

Its exquisitely simple elevation in no way infringes the law of just proportion between material and design. Perhaps we might suggest, with all due respect, that the beauty of the structure would in no wise be marred by the addition of a tub of earth which, placed in the middle of the barrier, would enable its seating accommodation to be largely increased.

This latter feature, perhaps, is most keenly appreciated. To sit at the front with the cool Borough air blowing down one's neck, while the eye zig-zags up and down the colonnade, following the chequers through clouds of tobacco-smoke, has delights which can only be appreciated by trial. Indeed, there is a rumour, possibly baseless, that one portion of the barrier is to be reserved for the Sisters and Nursing Staff. Well, perhaps!

From this advantageous position a very excellent view is obtained of everything that passes through the gates. It was from these reserved seats last Wednesday that a crowd of men watched the Grand Procession of Nurses to London Bridge, thence by special train to Mr. Bonsor's Garden Party. Just about half-past one o'clock a few frock-coats and carefully-ironed silk hats made their appearance, and slowly drifted off in the direction of the station. Then there was a sudden rush of nurses, all in clean bibs and tuckers, who collected together in the front quadrangle, where they were reinforced by several sisters. After a pause, during which they were unofficially inspected by Victor, the cortège moved off, with three hearty cheers from the reserved seats, and disappeared in the direction of London Bridge.

So this is the second garden party in connection with the hospital within a month. Everybody, of course, has heard all about our own prize-day, and about the beautiful hats and things that the men wore. But one little point has passed unnoticed, and that is a point which is very remarkable. Of the London men present in fancy dress, including the many as yet unqualified, there was not one who was not a graduate; many, it is true, forbore to wear the hood to which they were presumably entitled, but they all wore the long stuff graduate gown so familiar to habitués of Burlington Gardens. Doesn't that seem curious? From an æsthetic point of view, it would have been difficult to improve upon the appearance of the park on prize-day. The general effect of the neat nursing uniforms, the summer "toilettes," and the hoods and gowns of the graduates, was exceedingly pleasing.

The presence of the nurses on this occasion gave rise to the remark, that it was a pity that room could not be found in the programme for the prize-winners of the Nursing Staff. The idea seems excellent on the face of it, but possibly there are objections, not at once evident, but none the less fatal, when the subject is carefully considered. If this be so, one is forced to conclude that the London hospital has not gone into the matter sufficiently fully, for there, at any rate, the nurses receive their prizes at the public prize-giving.

But, anyhow, the whole affair was a distinct success. Cornelius came in for a good deal of praise, not altogether disinterested, for that ward was certainly the coolest spot in the hospital. Possibly this was the reason of the association of ideas that led an ingenuous maiden to ask whether Cornelius ward used to be a swimming bath. The remark is excusable, but should not be repeated.

When the band had played all its tunes and gone home, the hospital slipped back into ordinary life with remarkable rapidity, and a couple of hours later the only signs of festivity were deserted marquees and fragments of cherry cake; and these latter were absorbed in a very few days. There was no bunting, no lavish display of blue and old gold in decorations; the guests were the only decorations, and with their departure the hospital shook off her gala mien and resumed her stolid, every-day look. Perhaps it was as well that the hospital colours were not in evidence, for they certainly do not lend themselves readily to decoration. There is con-

siderable talk at present of changing the colours, or at any rate modifying them. The ordinary blue ribbon with a narrow central yellow streak, is certainly not pretty as seen on straw hats; nor is that arrangement worn only by Blues any better. It is difficult to imagine any pleasing design which should employ two colours, and the simplest way out of the difficulty would be for an art committee to fix on fresh colours, not necessarily restricting themselves to two, for the clubs. Of course, such a radical procedure as that would meet with immense opposition, especially from old Guy's men. Still, the matter appears to have reached a deadlock at present. Meanwhile, why not have a blue band with yellow spots, which by a simple mechanism could be made to *fade on pressure?* There you are, you see.

Pass List.

Second Conjoint Examination, July, 1899.

R. T. Collins, J. W. Gromitt, G. F. Humphreys, G. Moir, F. C. Robinson, W. A. G. Stevens, E. W. Strange, A. H. Turner, R. Willan.

(Four Year's Regulations.)

ANATOMY AND PHYSIOLOGY.—C. H. Gask.

ANATOMY ONLY.—T. Morgan.

School Examination in Elementary Anatomy, July, 1899.

H. O. M. Beadnell, S. C. Bowle, R. D. Bridger, C. F. Fraser, E. J. Gaffney, C. D. Horsley, R. St. G. Seagrove.

From the Gazette's Special Pathologist.

O. J. C., MARITZBURG.—The growth is malignant and not tuberculous. It is, in structure, a round-celled sarcoma, having in places a well-marked alveolar arrangement.

H. B., BUILTH WELLS.—This milk contains some pus, and sufficient blood to form a layer perfectly visible to the naked eye after centrifugalising. There are some streptococci present, and also a short diplo-bacillus in considerable numbers, which from its close relationship to the pus cells, is also playing some part as an infectious agent. No tubercle bacilli could be found, but it is pretty clear that the cow has had an inflammation of the udder from which it has not yet recovered, and therefore, in our opinion, the milk is unfit for consumption.

C. P., BARTON-UNDER-NEEDWOOD.—Microscopically the growth presents the characters of a scirrhus carcinoma of the breast. It is undergoing necrosis in parts.

E. R. M., HASTINGS.—No tubercle bacilli could be found in the sputum.

PATHOLOGIST.

Sport.

Cricket

GUY'S v. DUNSTABLE GRAMMAR SCHOOL.

Played at Dunstable, and drawn in our favour. Play was slow before lunch, but afterwards Wetherell and Langdale hit brilliantly. Dunstable had slightly over two hours' batting, and eventually, after a bad start, made the match a draw. Scores:—

GUY'S.

J. M. Brydone, c Heseltine, b Hyde	101
K. V. Trubshaw, b Thring	19
R. C. Poyser, c Alderson, b Fenn	18
G. S. Graham-Smith, run out	3
H. M. Langdale, not out	76
F. C. Wetherell, not out	47
Extras	37
Total (4 wickets)	301

S. C. Bowle, H. R. Grellet, J. T. Hicks, E. W. Strange, H. P. Wiltshire did not bat.

DUNSTABLE.

L. C. R. Thring, c Hicks, b Wiltshire	13
T. Healey, c Graham-Smith, b Wiltshire	3
C. C. Green, b Graham-Smith	7
W. Heseltine, c Hicks, b Graham-Smith	0
W. F. Brown, not out	52
J. H. Alderson, b Hicks	32
E. J. Hyde, b Wiltshire	8
A. J. Fenn, not out	11
Extras	21
Total (6 wickets)	147

H. C. Holloway, W. Nicholson, J. Cavanagh, did not bat.

GUY'S v. BRENTWOOD.

The return was played at Brentwood, and lost. The weather was brilliant and the wicket hard, but Guy's batted poorly against Heatley's fast bumping balls and Thornton's lobs. Clarke hit brilliantly, but otherwise the display was disappointing. The out-fielding was much improved. Wiltshire bowled well, repeatedly beating the batsmen, and Poyser took 3 for 9 in two overs. Scores:—

GUY'S.

A. E. Clarke, c & b Thornton	74
K. V. Trubshaw, c sub, b Claughton	8
R. C. Poyser, b Heatley	7
G. S. Graham-Smith, b Claughton	0
J. M. Brydone, c Lees, b Heatley	8
L. Humphry, lbw, b Thornton	3
H. Morres, c Winton, b Thornton	11
E. Cohen, b Thornton	0
H. Wacher, b Heatley	6
H. Palmer, not out	3
H. P. Wiltshire, b Thornton	9
Extras	17
Total	146

BRENTWOOD.

C. H. Escott, b Wiltshire	0
R. T. Thornton, c and b Graham-Smith	19

S. De Winton, lbw, b Clarke	40
A. E. Heatley, c Brydone, b Wiltshire	31
Major Claughton, c Palmer, b Wiltshire	18
D. Wommersley, c Clarke, b Poyser	41
C. Bear, c Humphrey, b Wiltshire	1
D. Milton, b Clarke	1
F. Young, b Poyser	14
Eley, c and b Poyser	0
Lees, not out	1
Extras	11
Total	177

Guy's Hospital Bicycle Club.

The Inter-Hospital Competition for the Cycling Shield was held on July 15th, at Sheen House Club. Guy's, who have held the shield for four years, were represented by the same team as last year, and after some keenly contested races, again proved their superiority by winning the competition by one and one-third points. Gabriel showed greatly improved form, and is to be congratulated on his consistent riding, which proved of immense value. May, who had a bad spill the week before, won his heat in the three miles, and gave a brilliant exhibition of his sprinting powers. Bates, who had been "taking-in," was unable to train for the races; despite this, he rode well, and showed but little effect from his hard work. Although competing against such well-known men as McBourke and Stuart, our men rode an excellent team race, which undoubtedly gained us the victory. At the close of the meeting Mrs. Silcock presented the shield and medals.

The shield, which is to be seen in its customary place in the smoking room, is the most valuable sporting trophy the hospital holds, and it is to be hoped that in future Guy's men will show a little more enthusiasm in matters connected with this energetic Club.

Guy's Hospital Lawn Tennis Club.

The return match v. Connaught had to be scratched, on account of the great number of men refusing to play. The previous Saturday's match v. Harold (July 8th), was scratched by our opponents.

GUY'S v. WANSTEAD.

Played July 22nd, at Wanstead, and resulted in a loss for the Hospital of 8 matches to 0, one drawn; 16 sets to 4, and 116 games to 71. This result is not much to be wondered at, as only two of our first team representatives were playing, viz., Lacey and Jupp. We also turned up one man short, as our captain failed to put in an appearance. Dr. Hickman, an old Guy's man, and secretary to the Wanstead Club, was kind enough to take Mandy's place, and played with Pye-Smith. Lacey and Jupp played together as first pair, and considering that this is the first time they have played together, they played a pretty strong game. They took 3 of the 4 sets off their opponents, Dr. Hickman and Pye-Smith being responsible for the other set. After the match four of the team took advantage of Dr. and Mrs. Hickman's kind invitation to stay to supper, and spent a most enjoyable evening.

Score.—E. N. Jupp and H. K. Lacey lost to H. E. Macadam and N. Haynes, 3–6, 6–3, 4–6; lost to B. Blewitt and E. Harper, 2–6, 6–2, 3–6; drew with C. O. Macadam and P. J. Bangs, 12–10. V. E. Hickman and C. D. Pye-Smith lost to Blewitt and Harper, 0–6, 5–7; lost to Macadam and Haynes, 0–6, 2–6; lost to Macadam and Bangs, 4–6, 6–4, 3–6. T. E. Holmes and J. S. Steele Perkins lost to Macadam and Bangs, 4–6, 2–6; lost to Blewitt and Harper, 2–6, 2–6; lost to Macadam and Haynes, 1–6, 4–6.

Appointments.

CIVIL.

ELLIMAN, A. C., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer, *pro tem.*, by the St. Saviour's Board of Works, Southwark.

POLLOCK, JOHN ROBERT RUSSELL, L.R.C.P. Lond., M.R.C.S., has been re-appointed Medical Officer of Health for Tiverton.

NAVAL AND MILITARY.

SURGEON SIDNEY CRONEEN has been appointed to the *Lizard*.

LIEUT.-COLONEL W. E. SAUNDERS, C.B., R.A.M.C., is promoted to be Colonel. He received his first commission in 1871, and served in the Zulu war in 1879 (medal); in the Boer War in 1881; and in the campaign on the North-west Frontier of India in 1897–98 with the Tirah Expeditionary Force, as Principal Medical Officer on the line of communication (mentioned in Despatches, appointed a Companion of the Order of the Bath and awarded a medal and two clasps). Colonel Saunders has been appointed Principal Medical Officer of the North-Eastern District.

LIEUT. H. D. PACKER is posted to Newcastle-on-Tyne for temporary duty.

SURGEON-CAPTAIN E. W. SKINNER, having resigned his Volunteer appointment, ceases to belong to the Army Medical Reserve of Officers.

LIEUT.-COLONEL W. A. MAY, R.A.M.C., has been posted to Devonport, for duty.

LIEUT.-COLONEL C. G. W. LOWDELL, I.M.S., has retired from the Service.

MAJOR J. V. SALVAGE, M.D., M.S., is posted to Malta.

Marriage.

FAWCETT — FLEMING-BAXTER. — On July 15th, 1899, at St. Paul's Church, Avenue Road, N.W., John Fawcett, M.D., M.R.C.P. (Lond.), of 24, St. Thomas's Street, S.E., son of the late John Bisdee Fawcett, to May Fleming, younger daughter of H. Fleming-Baxter, of the Tower, Fitz-John's Avenue, N.W.

ED.—F. E. W.

Contents.

	PAGE
The Endowment of the Medical School	329-330
Prizes	330
Antitoxin Treatment of Diphtheria: Clinical Lecture by Dr. Washbourn	330-335
Hospital News	335-338
Case for Diagnosis	339
Papers by Guy's Men	339
A Case of Extensive Fracture about the Elbow-Joint treated on a Hodgen's Splint with satisfactory result	339-340
Nursing Notes	340
Passim	341-342
Resignation of Dr. J. F. W. Silk, Anæsthetist to Guy's Hospital	342-343
Nursing News	343
Correspondence: Locum Tenens; Consideration of Patient; That Hat-band again	343-344
Pass List	344-345
On the Decline of Scurvy: Paper by Surgeon C. Marsh Beadnell, R.N. (*Concluded*)	345-349
In Lighter Vein	349-350
Sport: The 220 Cup. Guy's Hospital Lawn Tennis Club —Guy's v. Wanstead; The Championship	350-352
Solution to Case for Diagnosis	352
Appointments	352

Calendar of Coming Events.

August, 1899.

Sat. 19.—Messrs. Golding-Bird and Dunn's take-in: Drs., A. D. Pearson and D. Forsyth; Cl., A. H. M. Saward.

Thur. 24.—Messrs. Howse and Jacobson's take-in; Drs. T. P. Fawley and E. G. Andrews; Cl., A. E. Clarke.

Mon. 28.—Library re-opens.

September

Mon. 4.—First M.B. Durham Examination begins.

Sat. 9.—October Appointment list closes.

Mon. 11.—Second M.B. Durham Examination begins. Names of Candidates for Entrance Scholarships to be sent to Medical School Office by this date.

Guy's Hospital Gazette,

AUGUST 19, 1899.

The Endowment of the Medical School.

About this time last year, after Mr. Balfour's eloquent speech in aid of the endowment of Medical Research at Guy's, we called attention in these columns to the very urgent necessity for liberal contributions to this end, both in the cause of pure science and the much greater cause of humanity. For medicine is of all branches of science the least likely to remain stationary, and the present activity of thought and research in the medical world is well shown by the ceaseless outpour of medical literature in all quarters of the globe.

In all directions, pathological and clinical, there are multitudes of workers, all striving to explain some hitherto inexplicable fact or phenomenon, and so add one small iota to the general quantum of human knowledge; and in medicine especially of the sciences all increase of knowledge tends to further the relief of human pain and sickness. But in this busy work-a-day world there is no time for the average man to turn aside from the ceaseless toil of ministering to the sick to undertake the work of research. In the pursuit of knowledge for the love of science itself there is no advertisement, no money, and a whole useful and brilliant lifetime may be spent in the wearisome acquisition of a meagre fact. At the present day it is quite noteworthy that of the large volume of original work which is done all over the world every year, the majority comes from two sources—Germany and America, and of these Germany leads the way. Both in the domains of pure thought and science as applied to medicine, in clinical observation and technical methods the Germans are usually nearly ten years ahead of us. In America, the progress is most marked in the direction of surgical technique and operative methods, both of course founded upon experimental research.

The reason is not far to seek. In Germany every medical man has to obtain a university degree before he is able to practice. University education is far cheaper than in England, and the universities are much more numerous. All the universities are state aided, and consequently the number of endowed professional chairs and lectureships, with their facilities for original research, afford havens of rest to numbers of scientific men, who, thus relieved from monetary anxiety, are able to pursue their investigations with no eye to the commercial aspect of their labours. The result is the marked pre-eminence of Germany in the scientific world.

In America the population contains a larger proportion of rich men who apparently take a greater interest in medicine, and the hospitals are more modern and well furnished with funds; the result is practically the same as in Germany, and the keynote of the success of both countries is the *Endowment* of pure research.

There is no money to be made in Physiology, there is no money to be made in Bacteriology, yet both these subjects, and especially the latter, the foundation of all modern pathology, are of vital importance in the science of medicine. The only way to get the best work done is to endow the lectureship with sufficient money to make it worth while for a genius to devote his

attention to that particular subject and nothing else. This in effect is the ideal before the eyes of those in the Medical School at Guy's, and it was the ideal which prompted Mr. Balfour to make his appeal last year.

Mr. Balfour's words were not uttered in vain, for during the year Sir Frederick Wills gave £5,000 to rebuild the Medical Library, Mr. Robert Gordon £1,200, and Lord Ashcombe £50. On prize day this year, Mr. Robert Gordon again appealed to the philanthropic world for the same object, and at the close of his speech a further sum of £1,000 was given by Mr. Pierpoint Morgan, and there, with smaller sums, the endowment stands at present.

The requirements of the Medical School ideal are :—

To complete the building of—	
The Museum	£10,000
Laboratory of Chemical Physiology	5,000
Laboratory of Histology	5,000
Laboratory of Biology	5,000
The Library	5,000
To endow lectureships, five at £10,000	50,000
To endow research scholarships, five at £5,000	25,000

While the hospital itself is in such desperate need of funds, and so many improvements so closely connected with the welfare of the patients are so urgently needed, it is impossible to turn the stream of public benevolence away from its well-established channel for the relief and cure of the sick poor around us. This special endowment of research is rather a matter that every Guy's man should keep in his mind to bring before the notice of those who are able to take a wide enough view to appreciate the advantages to humanity at large of every advance in medical science. By the assistance of such broad-minded philanthropists we may hope to make the medical history of Guy's Hospital as brilliant in the future and as beneficial to humanity as it has been in the past.

Prizes.

BEANEY PRIZE IN PATHOLOGY, 1899.

The above Prize has been awarded to Candidate No. 15, Mr. C. T. Hilton, and a Certificate to Candidate No. 16, Mr. F. Shufflebotham.

(Signed) LAURISTON E. SHAW, Dean.

Guy's Hospital, August 15th, 1899.

Antitoxin Treatment of Diphtheria.

CLINICAL LECTURE by Dr. WASHBOURN.

July 19th, 1899.

Gentlemen,—To-day I propose giving you short notes of two cases to illustrate the use of the diphtheria antitoxin.

The first case was that of a medical student, 28 years of age, who on the 13th June suffered from sore throat. On the 15th there was distinct exudation on the throat. Diphtheria was diagnosed and an injection of 600 units of antitoxin was given. On the next day, in the morning, a similar dose of antitoxin was administered, and he was admitted into the London Fever Hospital later on in the day.

On admission, the patient was suffering from a moderately severe attack of diphtheria. The general nutrition was good. The fauces were injected. There was moderate œdema below the uvula; also ulceration of the tonsils which were covered by dirty white membrane; tenderness and a little swelling of the submaxillary glands; no fœtor of the breath; voice a little hoarse, pulse 90, temperature 101°; 2,600 units of antitoxin were administered. On the 17th there was little change; temperature 100°; 2,000 units of antitoxin were given. On the next day he was better, the membrane had disappeared, temperature 99·4° respiration 19, pulse and temperature normal. On the 23rd, that is to say, eight days after the first injection of antitoxin, an erythematous rash was observed, but was not attended by pyrexia. During the course of the illness a little albumen was found once or twice in the urine. The patient recovered without any bad symptom, the only discomfort from the antitoxin being the rash which appeared on the eighth day.

The next case was that of a girl, sixteen years of age, a domestic servant. On the 4th of June she suffered from sore throat; on the next day swelling of the neck was observed. On the 6th there was running at the nose, and on the next day—that is, three days after the commencement of the sore throat—she was admitted into the London Fever Hospital. On admission, she was suffering from a severe attack of diphtheria; there was much fœtor of the breath, the general nutrition was good, and the mental state clear. Much œdema of the hard and soft palate; the uvula covered with thin membrane; tonsils and pharynx not seen on account of œdema; extensive enlargement of the glands, accompanied by much puffy swelling of the cellular tissue all

round the neck; larynx not obviously affected; pulse 90, respiration 24, temperature 102°, and the knee-jerks absent; 5,500 units of antitoxin were given. On June 8th the notes say:—"The membrane is thicker and extending farther over the palate. The tonsils, which can just be seen, are completely covered with membrane; there is well-marked rhinorrhœa; temperature 101°; 5,500 units antitoxin were given." On June 9th:—"Less membrane, but otherwise no improvement; in the morning 5,500 units antitoxin were administered, and in the evening another dose of 8,000 units; temperature now 100·4°." On June 9th:—"She is about the same. Some small subcutaneous hæmorrhages were observed; 8,000 units antitoxin were given; temperature 99°." On the 12th:—"Very much better; temperature normal. On the next day the note says:—"She is doing well." On the 14th:—"The membrane has disappeared, and patient appears very well," and the note adds:—"At this stage it is difficult to persuade her mother, who has just come up from the country, that the girl had been seriously ill, that she was still ill, and might possibly die." Two days later, on the 16th:—"The patient complains of pain in the chest and abdomen, there is vomiting, the pulse is 92, small, soft and very irregular." On the 18th she again suffered from "pain, and there is cantering action of the heart; marked pallor; vomiting is continuous; slight antitoxic rash without pyrexia." This condition continued, and on the 24th, four days later, "worse." On the 23rd:—"There is a great deal of pain and vomiting, rapid, irregular respiration, pulse normal, slight hæmatemesis."

She died in the afternoon. The urine contained a small amount of albumen during the attack, but there was never any suppression.

This case was severe from the onset, and there was extensive œdema of the soft palate, uvula, and the pillars of the fauces, swelling of the submaxillary glands, rhinorrhœa, and absence of knee-jerks.

A few subcutaneous hæmorrhages appeared, so that it was a case of hæmorrhagic diphtheria, although the hæmorrhagic part of the symptoms were never very pronounced. The symptoms all subsided, the membranes and the local conditions disappeared, and the patient apparently recovered; but some little time after the beginning of the attack she began to suffer from a certain group of symptoms which is of very serious import when arising either during the acute stage or during convalescence from diphtheria. These symptoms were pain in the abdomen and chest, vomiting, and rapid irregular respiration. These symptoms are supposed to be due to a paralysis of the vagus nerve. This nerve has a very extensive distribution supplying the stomach, the heart, the intestines, with efferent impulses, and taking afferent impulses from the lungs to the centres, and it is supposed that the above-mentioned symptoms are due to paralysis of this nerve. Whether they are so or not I am not prepared to say, but I think the symptoms are of a complex nature, and that in addition to an affection of the vagus, changes in the muscular tissue of the heart, and possibly in the other tissues of the body are also concerned. Whatever may be the cause, those symptoms may arise either during the acute stage or during convalescence from diphtheria, and they very frequently end fatally, as was the case here. I specially want to call your attention to the fact that the administration of antitoxin, although it was capable of curing the local condition of this patient, was not capable of preventing the onset of this group of symptoms.

But before attempting an explanation I must give you a general account of the principles which guide us in the treatment of diphtheria with antitoxin. In the first place, you must understand that diphtheria is one of the diseases which are called toxic disease. By that I mean that the diphtheria bacillus remains localised to certain parts of the body, generally the fauces, sometimes the larynx, and sometimes other parts, and during its growth in these parts it produces a toxin which is carried to different tissues and acts upon them deleteriously. It produces fatty changes in the heart and other organs, and a degeneration of the nerves. This neuritis frequently comes on at a late stage in the disease, after all the local symptoms have disappeared. One might suggest many explanations of this, but the main point is that the nerves seem to possess some mechanism which protects them, at any rate for a time, against the diphtheria toxin. Although the toxins are quickly absorbed and carried to the nerves and other parts of the body, yet sometimes the nerves are able to resist the action, and, as a rule, it is only at quite a late stage that they are affected.

In very severe cases of diphtheria the neuritis occurs during the acute condition, and you will notice that in our case there was some evidence of the nerves being acted upon by the poison at the very beginning, because the knee-jerks were found to be absent.

For all practical purposes we have to consider two forms of diphtheria—faucial and laryngeal, where the bacillus invades either the fauces or larynx. Different kinds of danger arise in these two forms of diphtheria. The tissues of the fauces are abundantly supplied with vessels and lymphatics, and as a consequence absorption readily takes place. In faucial diphtheria the chief danger is from the absorption of the diphtheria toxins. The mucous membrane of the larynx or of the trachea has a different structure to the mucous membrane of the tonsils; it has a surface of such a nature that absorption does not readily take place. Consequently marked toxic effects are infrequent in laryngeal diphtheria The dangers arising from laryngeal diphtheria are two: first, the inflammation in the larynx may block up the glottis or set up spasm and produce asphyxia; secondly, the inflammation may pass down the trachea into the lungs and produce broncho-pneumonia.

It is only an assumption that in diphtheria in the human subject the symptoms are due to the absorption of the toxins. But this can very easily be shown to be true in the case of animals. In animals, symptoms of diphtheria can be produced by injecting diphtherial toxines obtained from artificial cultivations. If you inject some of the toxin under the skin of the guinea-pig a local œdema ensues and the animal dies. Post-mortem, you find fatty degeneration of the heart, liver, kidneys, and if the animal has survived for a certain time, degeneration and inflammation of the nerves, a neuritis similar to that which you meet with in the human subject.

When recovery ensues from an attack of diphtheria, the principal mechanism is the formation of a substance called antitoxin in the blood. This substance possesses the power of neutralising the toxin and then renders the bacilli harmless. The latter are not destroyed and may continue living for some time.

The treatment of diphtheria with antitoxin is simply a method by which the natural process of recovery is augmented. The antitoxin is injected ready made without waiting for the tissues to form it themselves. That is the whole principle of the treatment of diphtheria with antitoxin.

The antitoxin is the blood-serum of animals which have undergone a form of diphtheria. The animal that is usually employed for the preparation of diphtheria antitoxin is the horse, and the horse is chosen for two reasons. In the first place, it is an animal which is sufficiently large to enable us to obtain a large quantity of blood without any difficulty. In the second place, the normal blood-serum of the horse has very slight toxic effects on the human subject.

The method which was formerly used to induce diphtheria in the horse was to inoculate it with living cultivation, but it is now found more exact to inject the toxins. The toxins are injected for several months, and at each injection more antitoxin appears in the blood. From time to time the serum is tested, and when the blood contains sufficient antitoxin it is used for the treatment of the human subject. The animal is bled from the external jungular vein, and the blood is collected with the strictest aseptic precautions in a vessel. It is allowed to clot, and the serum is pipetted off and filtered so as to get rid of any germs that may have accidentally got in during the bleeding. It is then placed in small bottles with a small quantity of antiseptic serum. The serum is standardized before use. The method of standardizing is based upon the principle of finding out the amount of the antitoxin which will neutralize a certain quantity of toxin. The unit employed was thus obtained. The toxin was first tested by experiment so as to find what was the minimum fatal dose for a guinea-pig. Ten times this quantity was then taken and mixed with varying quantities of the serum, and the mixture was injected under the skin of the guinea-pigs. If the quantity of serum which was used had neutralized the toxin, the animal was not affected; if the toxin was not neutralized the animal died. In this way the smallest quantity of serum which protected the animal against a ten-fold fatal dose of toxin was ascertained, and ten times the quantity is taken to represent a unit.

This method of standardizing antitoxin is now found to be inaccurate, because the diphtheria toxin cannot be obtained in the pure state. The impure toxin contains non-toxic substances which have the property of combining with the antitoxin, and these substances are present in varying proportions in different samples of tissue. By a complicated series of experiments, Ehrlich was able to eliminate this error and to obtain a standard antitoxin, which is preserved in the Government Testing Department at Berlin. If this standard were at any time lost, it would be again obtained by repeating his experiments. Antitoxins are now standardized by comparing them with this standard antitoxin. By a series of experiments the quantity of toxin A which is neutralised by a unit of the standard antitoxin is ascertained.

By a second series of experiments the amount of the antitoxin (we are testing) which will neutralise the quantity A of toxin is ascertained. In this way it is quite easy to compare any antitoxin with the standard antitoxin.

The serum that is usually prepared in England contains about 500 units in a cubic centimetre, but the serum sent out from different places varies in strength from 200 to as much as 1,000 units in each cubic centimetre.

An important point to consider is how long the serum will keep without deterioration. Roughly speaking, if the serum is kept in a dark and cool place, it will continue for as long as six months without undergoing any perceptible alteration.

Now with regard to the properties of serum. When tested upon animals the diphtheria serum is found to protect against infection by diphtheria bacilli, or injection of diphtheria toxin, if it is administered some time before or after inoculation. So it possesses prophylactic as well as therapeutic properties. In regard to prophylactic properties, the protection afforded by the injection of antitoxin only lasts about three or four weeks. At the end of that time the antitoxin disappears from the tissues, and the animal is no longer immune. That is of importance in connection with using diphtheria antitoxin as a prophylactic in the human subject. You must remember it is quite different from vaccination, inasmuch as the protection only lasts for a short period, while after vaccination the protection lasts for a very long time.

If you infect an animal with diphtheria and then inject antitoxin, you will require to use very much more antitoxin. The longer the period there is between the infection and the injection of the serum, the more antitoxin will be required. The earlier you inject serum the less you have to inject in order to protect the animal. And after a certain period it does not matter how much antitoxin you inject—it has no effect whatever in saving the animal from death, the toxin having so acted upon the tissues that no amount of antitoxin has the slightest effect. And we find the same results in the human subject.

As to the way in which the antitoxin acts, I have already told you that it acts simply by combining with the toxin. It combines chemically with the toxin and forms a harmless compound. This combination obeys the usual chemical laws. It requires a little time for the antitoxin to unite with the toxin. It requires a certain temperature, and there is a certain quantity of antitoxin which is capable of uniting with a definite quantity of toxin. Now, when you inject the diphtheria toxin into the tissues of an animal, the ill-effects of the toxin are due to the toxin combining with the tissues and so injuring them. If you inject antitoxin at the same time, the affinity of the antitoxin for the toxin is greater than the affinity of the tissues for the toxin, and as a consequence the toxin does not combine with the tissues. Now, it would appear that the affinity of the nervous tissues for the diphtheria toxin in the human subject is very great, and as a consequence, under certain circumstances, even after injection with antitoxin, the combination of the antitoxin and toxin can be broken up by the nervous tissue, the toxin combining with the nervous tissue, producing paralysis.

I have related, you will notice, that the patient had a very large quantity of antitoxin; altogether there were 32,500 units injected. Nevertheless the patient died of diphthereal paralysis. I believe that amount of antitoxin had combined with all the toxin that was produced, but the nervous tissue was able to extract the toxin from its combination, and as a consequence paralysis ensued.

There is any amount of statistical evidence of the value of antitoxin in the human subject. The cases of mortality in London have much diminished since the introduction of antitoxins, and this diminution has been more marked in the fever hospitals where antitoxin is most used than it has been in the rest of London.

It has been stated that the diminution in the mortality for diphtheria is due to the fact that since bacteriological diagnosis has been instituted, a large number of mild cases admitted are cases which previously would not have been recognised. The experience, however, of superintendents of fever hospitals in London is that just as many severe cases are admitted now as before.

But there is other evidence, and this evidence is exceedingly convincing. The mortality in tracheotomy for diphtheria has enormously diminished since the introduction of antitoxin. You must remember that in laryngeal diphtheria the diagnosis rests upon clinical and not upon bacteriological examination.

In the Metropolitan Asylums Board Hospitals, in 1894, the mortality in tracheotomy from diphtheria was 70·4 per cent. In 1895, when antitoxin commenced, it was 44·9; in 1896 it was 41. At Guy's some time ago I looked up the statistics with regard to tracheotomy in

children under five years of age. I must tell you that in all statistics for diphtheria it is important to have certain definite age periods, because the mortality in diphtheria increases very much in proportion to the youth of the patient. At Guy's, in children under five years of age, the mortality between the years 1887–94 for tracheotomy was 76·7 per cent. In 1895, when antitoxin was first introduced, the mortality was 28·2 per cent. There is no statistical evidence to show that the membrane does not so frequently spread from the fauces to the larynx under the administration of antitoxin, so this statistical evidence, I think, is quite convincing of the value of antitoxin. But besides this there is clinical evidence, evidence obtained from those who have had large experience in diphtheria. Quite apart from any individual observer there have been two Committees who have issued Reports. There was the Committee appointed by the Metropolitan Asylums Board Hospital, and the Committee appointed by the Clinical Society. In both instances a large number of cases was carefully reported upon, and both Committees were quite convinced of the value of antitoxin. The principal points noticed were these. First, the exudation clears off, and the glands subside much more rapidly under treatment of antitoxin. Secondly, there is marked improvement in the general condition of the patient. Thirdly, the extension of the membrane to the lungs is much less frequent than before.

Now, with regard to paralysis, I have already hinted to you that diphtheria antitoxin has no very marked influences. As a matter of fact, if you take statistical evidence you will find that there is a greater incidence of paralysis in cases treated with antitoxin than in cases not so treated. But in the cases which are not treated by antitoxin there is a large number of fatal cases, and many of these fatal cases would, no doubt, have developed paralysis had they lived.

I believe that really, as far as paralysis is concerned, the antitoxin has not had any very marked effect one way or the other.

There is another point that has been admitted by everybody, and that is, the earlier the antitoxin is administered the better the results. There is abundance of statistical evidence both in England and abroad pointing to this.

With regard to the administration of antitoxin, it is given by subcutaneous injection. It is useless to adminster it by the mouth because it is destroyed before it reaches the general circulation. It is destroyed probably by the liver cells.

With regard to the dose, in severe cases you give about 5,000 units, or 10 c.c. of a serum containing 500 units per cubic centimetre, which should be repeated two or three times at intervals of twelve hours, in accordance with the progress of the case. In very severe cases you may give a dose of from 8,000 to 10,000 units, repeating them in the same way as in moderately severe cases. In mild cases you may give less. If, after two or three days' treatment with antitoxin, you find no definite improvement, it is not worth while continuing the injections. For purposes of prophylaxis a much smaller quantity of antitoxin is required —200 or 300 units. The protection is only afforded for two or three weeks.

There are certain ill effects that may arise after the injection of antitoxin.

I must remind you, in the first place, that the serum of one species of animal is almost always toxic, to a certain extent, to another animal. If you inject the serum of one species of animal into an animal of the same species, no toxic effects arise, but if you inject the serum of an animal of another species, toxic effects are produced. The toxicity of serum has been measured in this way. Serum is slowly injected into the circulation of a rabbit, and the amount of serum which causes death is taken as an index of its poisonous character. It is found, to the rabbit at any rate, that cow's serum is the most toxic, and if you slowly inject cow's serum into the circulation, the animal dies when a quantity corresponding to six cubic centimetres for every kilogram in weight of the animal, has been injected.

There are other effects that may be produced upon animals by injection. If you inject a smaller quantity of serum the animal does not die, but suffers from pyrexia.

In the human subject the injection of the normal serum of various animals has been tried on many occasions, and it has been found to produce a number of different symptoms. In the first place, it produces rashes, which usually come on some time (a week or fortnight), after the injection of serum. It sometimes produces joint pains. Both rashes and joint pains are attended, as a rule, with pyrexia. Sometimes the injection of serum produces no pain in the joint and no rash, but pyrexia alone.

It is known, also that after an injection of antitoxic serum of various kinds, as, for instance, anti-diphtheria serum, anti-tetanus serum, anti-streptococcal serum, a number of

symptoms arise. In the first place, it causes rashes, joint pains and pyrexia.

The rashes are, as a rule, either of an erythematous or of an urticarial nature alone, and sometimes merely a patch of urticaria. The rash affects most of the body, especially the extensor surfaces of the limbs. The rash may be exactly like the rash of measles, and when accompanied by pyrexia there may be a good deal of difficulty in distinguishing the one from the other.

In some cases the rash is of a type which may closely resemble that of scarlet fever.

In a very few instances purpuric hæmorrhages into the skin have been noticed, but that seems to be exceedingly rare.

The rash usually appears on the eighth day, but they may occur immediately, or as late as the thirty-first day. A very important point is that certain specimens of serum produce rashes, and joint pains much more frequently than others. In the very early days of antitoxin this fact was noticed, and a number of experiments have been made to find out what is the cause of certain specimens of serum producing these effects more than the others. It is found that if the serum is allowed to remain very long in contact with the clot it is more toxic to animals. And not only has it a more toxic effect, but also a more pyrexial effect. It would appear that by heating the serum to about 60° C. you can do away with its property of producing fever. Therefore it seems to be quite possible that in the near future some means will be adopted by which these ill-effects can be annulled.

Beside the rashes, joint pains, and pyrexia, there are certain other conditions that have occurred, although very rarely, after the injection of antitoxin, conditions which have been of serious import.

In the first place, one or two cases have been recorded in which serious collapse has arisen immediately after the injection, and in some cases this collapse has ended fatally. There was a case of a child who was given a preventive dose of diphtheria antitoxin, and who became collapsed and died within five minutes.

There are other cases in which toxic symptoms have arisen immediately after injection of the serum. A rash has appeared within a few minutes of the injection, with rigors, high temperature, convulsions, and collapse—cases in which patients have been so seriously ill as to give rise to very grave doubts of their recovery. Several such cases have been recorded; three cases were recorded here in England by Dr. Goodall, and other cases have occurred abroad.

There are other ill-effects that may arise from an injection of serum. A septic condition may occur if proper aseptic precautions are not observed, or if the serum has become contaminated. I had brought to my notice two cases in which children were injected with diphtheria serum. These children, seven hours after injection, were seized with severe vomiting and diarrhœa, the temperature rose rapidly, and they both died within twelve hours. I had a sample of the serum sent to me, and found that it contained a large number of cocci. Consequently the injection of antitoxin is not absolutely devoid of risk. Nevertheless, the risks can be considerably diminished by due care, and in any case they are much smaller than the risks which a patient suffering from diphtheria runs when not treated with antitoxin.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Pye-Smith.

Mary	25.	Osteo-arthritis. ? Paralysis agitans.
	26.	Bronchitis and emphysema. Anasarca.
	27.	Osteo-arthritis.
	28.	Disseminated choroiditis.
	29.	Left empyema. Resection of rib.
	30.	Tumor cerebri. Optic neuritis.
	31.	Chorea.
	32.	Mitral stenosis and incompetence. Acute rheumatism.
	33.	Ovarian cyst. Ascites.
	34.	Mitral incompetence. Acute rheumatism.
	35.	Mitral incompetence. Acute rheumatism.
	36.	Morbus Brightii. ? Tuberculous pyelitis.
Philip	21.	Hepar auctum. ? Secondary carcinoma.
	22.	Acute rheumatism. No endocarditis.
	23.	Tuberculous peritonitis. Albuminuria.
	24.	Chronic tubal nephritis.
	25.	Urticaria ab ingestis.
	28.	Diabetes. Peripheral neuritis. Left apex.
	29.	Renal anasarca.
	31.	Malignant stricture of pylorus and colon. Gastro-jejunostomy. Right inguinal colotomy.
	32.	Tumour in left loin. Exploration.

Philip 33. Anæmia. Irregular heart. Localized apical systolic bruit. ? Tobacco.
34. Nephralgia.
35. Gastro-enteritis.
36. Mitral stenosis and incompetence. Acute rheumatism.
37. Ascites. Abdominal carcinoma. Paracentesis abdominis.
38. Eczema.
39. Right pleuritic effusion.
40. Pneumo-hydro-thorax following pleurisy. Probably tuberculous.

Cases under Dr. Shaw (for Dr. Taylor).

Mary 38. Mitral regurgitation. Fibroid lung. ? Rheumatic.
39. Carcinoma recti. Secondary growth in liver.
41. Marasmus. D. & V.
42. Mitral regurgitation. Rheumatic.
44. Carcinoma of stomach.
45. Chorea. Relapse of first attack.
46. Pleurisy with effusion. ? Tuberculous.
47. Pemphigus.
48. Gastric ulcer.
49. Ascites. ? Chronic peritonitis.
Cot 56. Intermittent pyrexia. ? Meningitis.
57. Bright's disease.
Stephen 1. Chronic Bright. Heart failure. Right hydro-thorax. Tapped.
2. Pleuritic effusion. Tapped ʒxxxii.
3. Appendicitis.
4. Acute rheumatism.
5. Pyloric stenosis. ? Healed ulcer. Dilated stomach.
7. Mitral stenosis and regurgitation.
9. Diabetes mellitus.
10. Sciatica.
11. Emphysema. Bronchitis. General anasarca.
12. Jaundice. Carcinoma.
13. Enteric fever.
14. Lobar pneumonia. Right apex.
15. Enteric fever.
16. Broncho-pneumonia.
17. Diabetes mellitus.
18. Retro-peritoneal abscess.
19. Jaundice. ? Cirrhosis hepatis. ? Growth.
20. Bright's disease. Acute on chronic.

Cases under Dr. Hale White.

Mary 13. Phthisis.
14. Gastric ulcer.
16. Empyema.
17. Chronic peritonitis. ? Tubercle.
18. Gastric ulcer.
19. Adiposis dolorosa.
20. Aberrant varices. Raynaud's disease.
22. Cerebral tumour. Operation.
23. Pleurisy and pericarditis.
24. Bright's disease.
Cot 53. Ulceration of mouth.
54. Diarrhœa and vomiting.
Philip 1. Rheumatic endocarditis. Mitral stenosis and regurgitation.
3. Acute nephritis. Tubal.
4. Infective endocarditis.
5. Perityphlitis.
6. Pyrexia.
7. Mitral regurgitation. Ascites.
8. Mitral regurgitation and stenosis. Aortic stenosis.
9. Mitral regurgitation.
10. Gout.
11. Duodenal ulcer. Melæna.
12. Carcinoma ventriculi.
14. Bronchiectasis and fibroid lung. Æt. 5.
15. Chronic nephritis.
16. Acute tubal nephritis.
17. Acute rheumatism. Mitral regurgitation. Aortic stenosis.
19. Pyrexia. ? Typhoid.
20. Acute rheumatism. Mitral stenosis and regurgitation.

Cases under Dr. Pitt.

Mary 1. Malignant endocarditis.
2. Mitral regurgitation.
3. Uræmia.
4. Pneumonia. Otitis media.
5. Chronic myelitis.
6. Cirrhosis of liver. Ascites.
7. Malignant growth of gall-bladder. Laparotomy.
8. Pleural effusion.
9. Malignant growth of sigmoid. Colotomy.
10. Acute eczema.
12. Chronic tubal nephritis.
Cot 51. Diarrhœa and vomiting.
52. Tuberculous broncho-pneumonia.
Stephen 21. ? Malignant growth of spine.
22. Pleural effusion.
24. Pericarditis.
27. Mitral stenosis and regurgitation.
28. Mitral stenosis. Emphysema.
32. Locomotor ataxia.
33. Acute rheumatism. Mitral regurgitation.
34. Acute rheumatism.
36. Syphilitic softening of brain. Cross paralysis.
37. Gangrene of lung.
38. Paralysis agitans.
39. Diabetes mellitus.
40. Empyema.

"Clinical."

2. Creolin poisoning. Broncho-pneumonia. Death.
3. Purpura. ? Chronic Bright's disease.
5. Enterica.
8. Gastro-enteritis.
9. Appendicitis.
11. Lobar pneumonia.
12. Pelvic growth. Exploration.
13. ? Carcinoma ventriculi.
15. Right hemiplegia. Right facial paralysis. Sensory aphasia.
16. Lobar pneumonia.
17. Creolin poisoning.
18. Enterica.
19. Enterica.
21. Gastritis.
22. Hæmatemesis. ? Cirrhosis of liver.
23. Mitral regurgitation and stenosis. Tricuspid regurgitation.
25. Enterica.
26. Right pleuro-pneumonia.
28. Acute rheumatism. Mitral regurgitation.
30. Broncho-pneumonia.
31. Lobar pneumonia.
32. Leuchæmia.

Cot 33. Laryngeal diphtheria.

34. Diphtheria. Tracheotomy.
35. Lobar pneumonia.

In the Surgical Wards.

Cases under Mr. Howse (Mr. Jacobson acting).

Naaman
1. Stricture.
3. Old tuberculous hip with abscess.
4. Old excision of tuberculous hip with sinus. Furneaux-Jordan's amputation.
5. Breaking down sarcoma in neck. Incised and drained.
6. Tuberculous knee.
7. Undescended testis. Congenital hernia (left). Hydrocele of cord (right).
8. Enlarged prostate. Supra-pubic puncture.
9. Sarcoma testis. Castration.
10. Enlarged prostate.
12. Enlarged prostate. Inguinal hernia.
13. Appendicular abscess. Fæcal fistula.
14. Irreducible inguinal hernia.
16. Empyema. Previous drainage. Ribs resected.
18. Iliac caries with abscess.

Dorcas
2. Mastoid abscess. Antrectomy.
3. Tuberculous glands in neck. Excised.
4. Strangulated femoral hernia. Kelotomy.
5. Nasal polypi.

Dorcas
6. Pott's fracture.
7. Gummatous ulceration over and arthriti of elbow.
8. Tuberculous ankle.
9. Iliac abscess. Drained.
11. Strangulated femoral hernia. Kelotomy.
12. Tuberculous axillary glands.
17. Ruptured eye-ball. Excised.

Cot B. Acute epiphysitis of humerus. Incised.

C. Cleft palate.

Astley Cooper
1. Ruptured urethra. Perineal section.
2. Compound fracture tibia and fibula. Wired.
6. Fractured ribs.
7. Fractured spine. Died.
9. Fractured patella.
20. Fractured femur.
29. Fractured scapula.
32. Stab in abdomen. Penetrating.

Cases under Mr. Davies-Colley.

Job
2. Dupuytren's contraction. Operation.
3. Ununited fracture of tibia with necrosis. Sequestrotomy.
4. Tuberculous testis and other tuberculous lesions. Castration.
9. Iliac abscess from spinal caries.
10. Stricture.
11. Stricture.
20. Sarcoma of tonsil and glands. Removed.
21. Old tuberculous hip with flexion.
23. Abscess over sternum. Incised.
25. Fibrous ankylosis of hip and knee, with necrosis of femur.

Lydia
1. Renal sinus after nephrotomy for ? calculous pyonephrosis.
3. Urethral impacted calculus.
4. Tuberculous hip. Excised.
5. Bullet in brain. Explored.
6. Mastoid abscess. ? Cerebral abscess.
7. Rodent ulcer on forehead. Excised.
8. Genu valgum.
10. Hæmorrhage from sloughing palmar wound.
12. Rodent ulcer of nose. Excised.
13. Fractured pelvis.
14. Mastoid abscess. Antrectomy.
15. Compound tibia and fibula.
18. Genu valgum.

Cot A. Cleft palate and hare-lip.

Cornelius
3. Penetrating wound of elbow with fractured radius.
4. Penetrating wound of knee.
7. Fractured mandible. Double. Wired.
8. Fractured femur.
11. Compound fracture of tibia and fibula.
14. Fractured mandible. Double. Wired.
16. Fractured neck of femur.
18. Fractured femur.

CASES UNDER MR. LUCAS (Mr. Fripp acting).

LAZARUS 3. Double inguinal hernia. Reducible.
4. Acute appendicitis.
5. Ankylosed tuberculous hip.
6. Melanotic sarcomatous glands in neck. Excised. No obvious primary cause.
8. Suppurating temporal hæmatoma. Hemiplegia and aphasia. Trephined. Intradural abscess. Drained. Pachymeningitis. Death.
16. Stricture.
17. Tuberculous glands in neck.
18. Strangulated inguinal hernia.
19. Old tuberculous hip with abscess.
20. Recurrent epitheliomatous glands in neck. Excised.
21. Old hip disease. Iliac caries.
22. Irreducible inguinal hernia.

MARTHA 2. Old tuberculous knee. Previously excised. Further caries.
4. Sarcoma mammæ. Excised.
5. Cut throat.
6. Mastoid abscess. Antrectomy.
7. Adenoma mammæ.
8. Carcinoma mammæ. Skin involved.
15. Talipes equino-varus. ? Congenital.
16. Compound fracture of tibia and fibula.
17. Malignant iliac glands. ? Secondary to sigmoid cancer. Cancerous peritonitis.
19. Bullet in brain. Extracted.
20. Fractured femur.
21. Calculous pyonephrosis. Nephrolithotomy.

Cot A. Fracture of humerus. Supra condylar. T-shaped.
B. Strangulated inguinal hernia. Kelotomy.

ASTLEY COOPER 7. Fractured mandible.
10. Compound fracture of tibia and fibula.
13. Compound fracture of femur, tibia and fibula.
24. Fractured femur.
25. Fractured dislocation of spine. Sixth dorsal.
29. ? Traumatic pneumonia.
30. Foreign body (piece of steel) in knee-joint.

CASES UNDER MR. GOLDING-BIRD (Mr. Dunn acting).

LUKE 5. Hydrocele of hernial sac. Radical cure.
6. Moveable kidney. Nephrorraphy.
7. Necrosis of radius.
8. Old dislocation of elbow. Excised.
10. Old tuberculous hip.
11. Colotomy for ulcerative colitis.
13. Stricture with retention.
20. Epithelioma linguæ.
21. Recurrent appendicitis.

CHARITY 2. Ventral hernia.
3. Strangulated femoral hernia. Kelotomy.
5. Moveable kidney.
6. Cystic breast. Amputated.
7. Clin. P. R. Moveable kidney. Nephrorraphy.
8. Sarcoma of breast. Excised.
9. Fractured olecranon.
10. Tuberculous cervical and axillary glands.
11. Fibrous stricture of rectum. Inguinal colotomy.
12. Adenomata mammæ. Excised.
13. Bronchocele.
15. Adenoma mammæ.
16. Appendicular sinus.
17. Paget's nipple. Breast excised.
18. Rodent ulcer. Excised.

Cot A. Meningocele. Radical cure.
B. Talipes equino-varus.

ASTLEY COOPER 12. ? Fractured neck of femur.
19. Fractured femur.

CASES UNDER MR. JACOBSON.

NA'AMAN 19. Dislocation of sterno-clavicle joint. Resected.

DORCAS 21. Recurrent appendicitis.

PATIENCE 4. Necrosis of amputation stump.

CASES UNDER MR. SYMONDS (Mr. Fripp acting).

JOB 13. Recurrent sarcoma of tonsil.
14. Old ruptured urethra. Stricture.
15. Recurrent sarcoma of maxilla.
16. Sarcoma of tonsil. Excised.

LYDIA 21. Adenoma mammæ.

SAMARITAN 10. ? Salivary fistula.

CASES UNDER MR. LANE (Mr. Fripp acting).

LAZARUS 11. Appendicular fæcal fistula.
12. Otitis media. Mastoid abscess. Brain explored.
14. Tuberculous testes. Castration.

MARTHA 12. Irreducible umbilical hernia.
13. ? Hydronephrotic kidney. ? Ovarian cyst.

Cot C. Talipes equino-varus.

CASES UNDER MR. DUNN.

LUKE 1. Renal hæmaturia. ? Growth.
2. Recurrent epitheliomatous glands. Excised.
3. Vesical calculus.

CHARITY 15. Adenoma mammæ.
20. Carcinoma recti.
21. Irreducible inguinal hernia.

Cot D. Bilateral inguinal hernia.

PATIENCE 3. Acute mastitis.

Case for Diagnosis.

Eliza M., æt. 20, was on the afternoon of the 13th walking with a girl friend, and seemingly in her usual health, when she suddenly began to laugh, and her friend noticed that the right side of her mouth was drawn up; she asked what was the matter, to which the girl replied that she was all right; almost immediately, however, her left foot began to drag, and she was unable to walk on. She was helped into a public-house and sat down, but while some brandy was being fetched she fell off her seat on to the ground; for a few minutes she was able to answer questions, but then became totally unconscious; there were at this time some spasmodic movements of the right side of the face and left arm. She was immediately brought to the hospital, and when first seen she was totally unconscious, the breathing was quiet, no facial paralysis was evident, and the pupils were equal and not dilated. Soon afterwards, however, the right pupil was noticed to be widely dilated, while the left remained small, the breathing also became stertorous, and the patient vomited some undigested food; at the same time there were some clonic movements of the right arm, while the left hung almost motionless, though it did move very slightly; the left leg was also more flaccid than the right.

On admission to the ward, both pupils were widely dilated, and insensitive to light. There was some rigidity of all four limbs, which passed off almost immediately, leaving them completely flaccid. The knee-jerks were increased, the plantar reflex absent. The pulse was full and regular, 64 to the minute, and the heart sounds were normal. The respirations were 16 to the minute, rather shallow and irregular. The temperature was subnormal, and the mercury of a thermometer placed in the axilla did not rise at all. There was some stertor, but no blowing out of the cheeks. Neither urine nor fæces were passed. There were no signs of syphilis. The pulse and respiration became gradually weaker and more irregular, and about an hour after admission a quantity of pink froth poured from the mouth, respiration ceased save for an occasional short gasp, and the patient died about two hours after the first symptom, without having recovered consciousness. She had had rheumatism six years before, and "a bilious attack" two weeks before.

(*For Post-mortem Result see page 352.*)

Papers by Guy's Men.

Methods of Exposing the Pelvis of the Kidney and the Ureter for Surgical Treatment. By Henry Morris, M.B., F.R.C.S.—*Clinical Journal*, 28th June.

On the Importance of Plastic Surgery in Renal Distension (*i.e.* Nephrectasis); with special reference to Stenosis of the Ureter. By Henry Morris, F.R.C.S. Eng. —*Lancet*, 1st July, 1899.

A Case of Extensive Fracture about the Elbow-Joint treated on a Hodgen's Splint with satisfactory result.

A. B., a police sergeant, of powerful build, was admitted into Astley Cooper ward, under Mr. Clement Lucas, in May last. He had fallen heavily on to his left elbow, and there was a very considerable extravasation of blood both into and around the joint. On examination, the two condyles of the humerus were found separated from the shaft and easily movable on one another. The olecranon process was also fractured. A separation of the head of the radius was suspected, but the after result proved that this had not taken place. There was no particular displacement of the fragments.

It was pointed out to the man that a bad result, as regards mobility and usefulness of the limb, would very likely follow so serious an injury if treated with splints in the Surgery, and he was advised to come into the hospital, so that the best possible treatment could be carried out, although a very guarded prognosis was given.

It was decided to treat the injury by extension in the axis of the limb, and to apply the extension by means of a Hodgen's splint adapted to the upper extremity. A stirrup was accordingly strapped to the forearm from the wrist to about two inches below the elbow, and the next day a small straight Hodgen was applied. The forearm was fully extended and supinated, and the limb was supported by the flannel bands from the middle of the arm to the wrist-joint. It was not found necessary to increase the amount of extension beyond that caused by the weight of the very well-developed arm. The elbow was massaged daily as far as possible, the swelling rapidly diminishing.

On the 17th day the limb was taken down from the splint, and cautiously flexed without using force. It was again straightened and replaced on the splint. This was repeated daily for four days. At the end of that time—that is to say, 21 days after the injury—the elbow could be easily flexed to a little less than a right angle, and the patient got up with the arm supported in a sling. No movement of the fragments could be detected. There was much callus formation about the lower end of the humerus, but none about the radius, and pronation and supination were but slightly limited. From that day, active and passive movements were vigorously carried out, and a steady increase in power took place. At the end of five weeks, while the patient had not nearly as much power in the arm as he has now, yet the amount of movement at the elbow-joint was very much what it is at present, as described below.

He can now, some three months after the accident, actively flex the elbow-joint through 95°. Fully extended, the forearm makes an angle of 165° with the arm; fully flexed, an angle of 70°. By passive movement the latter angle can be reduced to 45°. He can

easily lift 56lbs., and pronation and supination are almost perfect. For all practical purposes the limb is as good as ever.

In view of the greatly diminished usefulness of the arm which so often follows fractures of the humerus involving the elbow-joint, the above case is distinctly encouraging. The association of a T-shaped fracture of the humerus with a fractured olecranon gave rise to a quite remarkable amount of mobility about the joint, the most gentle movement giving rise to crepitus. One successful result does not prove much, but it is at least an indication for a furthur trial of the method of extension in fractures of the same nature. There is, of course, no particular virtue in a Hodgen—a weight and pulley would produce extension equally well—but it is an exceedingly comfortable appliance, and allows of much freedom of movement; exactly the same advantages as in the case of a fractured femur. There is no difficulty in applying it; the tendency of the strapping to slip owing to the shape of the forearm is more than compensated by the way in which the wrist-joint tolerates extension.

H. W. BRUCE.

Nursing Notes.

Both garden parties were simply immense. We have been reading the dictionary to find sufficient adjectives and appropriate language to describe them in, and failed.

There was nothing lacking for everyone's comfort and happiness. The way was made easy to the station by Dr. Perry acting as sign-post at the critical junction of the rival lines, and preventing those nurses who were late from plunging into the wrong station. Further there was the special train, which imparted a tone of royalty to the procession. The walk through the grounds was lovely, no one was requested to keep off the grass, and the hill was crowned with a refreshment tent. We must remark that everyone made a bee-line for it; it is rumoured that one never left it, she said she could hear the band best from that spot.

One of our spiritual guides who was there (we don't mean either of the chaplains) was heard to murmur in the act of swallowing a large ice "Oh! Paradise, Oh! Paradise." No one is certain whether he meant the ice or the scenery, but we quite agree with him in either case.

We all enjoyed it so much that we should be quite willing, even anxious, for Mr. and Mrs. Cosmo Bonsor to make arrangements with the authorities for us to go down once a week, special train included.

The nurses are madly jealous—the sisters have *menus*, the nurses haven't. Under the old system it wasn't necessary, for each day brought its appointed dish. With unfailing regularity eggs appeared on Monday for breakfast, sardines on Tuesday, and so on; but things are changed now. Last week sardines appeared on Friday, and half the nurses went to the ward and performed Tuesday's work till dinner-time, when a pudding belonging to Saturday's dinner was put on the table; this was very confusing, and the matter was inquired into. Now, no man can say what shall be eaten from day to day. (We had no idea they were ever allowed to.—Ed.) It certainly makes the meals more appetising, and everyone is inclined to be pleased with the new management.

A dresser asked a nurse the other day to bring him No. 10's dressings. She disappeared with a perplexed look on her face, but soon re-appeared with a bundle containing the patient's clothes.

The announcement that the lift wouldn't be working for a month struck a mild panic amongst the nurses on the medical side, but it hasn't been missed very much so far. It has been useful sometimes as an excuse for being late in the wards, as "I came up in the lift" would explain away the fact of a nurse being a quarter of an hour late on duty. It had an unfortunate habit of hanging 'twixt heaven and earth if even mildly loaded up. There is a story of how it stopped most unaccountably between floors for over twenty minutes when it was only occupied by a man and a maid—but we forget, this column doesn't chronicle such tales.

Scene.—*The Eye Wards.*

Dramatis Personæ.—The Assistant Matron.
The Staff Nurse.
Mr. B——y.

The A. M. discovered talking to the S. N. Mr. B——y pokes his head round the corner, condescendingly to the A. M. "Oh! it's you is it? Well you need not go, you may stay where you are."

Consternation on part of S. N., amusement on part of A. M.

"L'INCONNUE."

Passim.

August, and the thermometer 90° in the shade! Small wonder then that nothing is doing in the hospital, or that no one wishes to exceed his own little irreducible minimum of work. But rather the whole world of Guy's prefers to stand by and watch while in the sweltering surgery the perspiring H.-P.'s and Clinicals resignedly attack the annual problem of the prevention and cure of vomiting and diarrhœa among the *jeunesse dorée* of the lower classes.

On the social side of the hospital, too, there is such a dearth of news that we are almost inclined to agree with our entertaining contemporary, the *D.T.*, and ask ourselves, "Are Appearances worth keeping up?" and why should Guy's alone among other hospitals try to make the outside world believe that it is anything else than a desert by bringing out Gazettes all through the long vacation.

However, it is no use railing against the powers that be, Gazettes there have to be; so we warn all readers that if they want news they will not find it in these pages. Are there not the cricket editions of the halfpenny evening papers?

Though there is no giant gooseberry or sea serpent to record, in our own small way we might invite contributors on the subject of Locum Tenentes (to be correct). As will be seen in another column, there has been laid the groundwork of what might become a very pretty silly season correspondence; two letters, one from "F.R.C.S.," a gentleman who, we have reason to believe, has had varied experience in many places, the other from the enthusiastic pen of Mr. F. E. Fremantle, full to the brim with the *joie de vivre* of his first locum. Other contributors on this distressful subject will be welcomed with open arms.

We deeply regret to announce the sudden and unexpected death of Arthur E. Earnshaw, M.B., which occurred at Bradford on Friday, August 11th. He had been quite well up to three weeks ago, but then had an attack of acute appendicitis. As he continued ill, operative treatment was resorted to, with no good result, and he died rather suddenly on Friday evening. He had been at Bradford for some time, and had become extremely popular, and his unexpected death has provoked a wide-felt expression of sympathy and regret. Arthur Earnshaw entered Guy's in 1890, and qualified at the colleges in 1896, subsequently taking his M.B. in 1897. He held the posts of Clinical and Resident Obstetric here, and after leaving Guy's he was for some time Resident Medical Officer at the Dreadnought Hospital. From there he went to Bradford Infirmary, and just before his illness was contemplating resigning his post in order to come up to London again to read for his M.D.

In the Medical School Green Book for the coming year there is an announcement of great interest and importance to all men going up for their final F.R.C.S. in the future. We refer to the particulars of classes which are to be held this year for six weeks before the examinations in May and November, solely for the men who intend going up for these examinations. This step is a great advance and ought at once to do away with the necessity of attending post-graduate classes at other London Hospitals, as was the case formerly. We understand that the classes will be drawn up on lines very similar to those suggested by Mr. A. W. Ormond in his letter upon the subject to the columns of the Gazette in the autumn of last year.

Another important innovation in the Medical School curriculum is that of Clinical Lectures on Special Subjects. It is proposed that during next year clinical lectures will be given every Monday afternoon on special subjects—Eyes, Ears, Throat, etc., in rotation. These lectures will also be of great value to men going up for the higher examinations, and will further emphasize the value of the large field of clinical observation available to all men in the special departments at this hospital.

We very much regret to announce that Dr. E. H. Starling has handed in his resignation of the post of lecturer on Physiology and head of the Physiological Department. Dr. Starling has been elected to the chair of physiology at University College, Gower Street, in the place of Professor Schäfer, who has gone to Edinburgh. We congratulate him on his selection for the most coveted physiological appointment in London, but we can only regret the loss to Guy's of one of its best-known men and most original thinkers.

As Mr. Minchin has also resigned the post of lecturer on biology—another great loss to the

Medical School—there are two very important vacancies to be filled before the commencement of the next year; and vacancies, too, which apparently will have to be filled from outside, as there are at present none among the younger generation of men quite qualified to fill either post. But a little new blood infused into an institution such as this seldom does any harm, and more often does much good. For a successful medical school good teachers are absolutely essential.

ON June 30th, Dr. G. H. Graham, of Storrington, was presented with a handsome silver tea and coffee service by a large number of friends and patients on the occasion of his leaving the neighbourhood after fifteen years' practice. In a letter accompanying the gift, the vicar of Storrington further emphasized the high esteem in which Dr. Graham had always been held, and pointed out the absolutely spontaneous nature of the presentation. Dr. Graham is a Guy's man and qualified in 1884, when he went straight to Storrington.

WE are glad to notice the return of Dr. Reginald Koettlitz, who has just been through Abyssinia from east to west as medical officer on the Weld-Blundell Expedition. In an interview published in a daily paper, he gave many interesting details of a most remarkable journey. It will be remembered that Dr. Koettlitz also accompanied the Jackson-Harmsworth Expedition to the North Pole in a similar capacity, and wrote an account of his experiences in the pages of the GAZETTE.

THROUGH the generosity of Mr. F. E. Beddard of the Zoological Society, whom most Guy's men will remember as a teacher here a year or two ago, four valuable specimens have just been added to the Comparative Anatomy Section of the Dental Museum. He has presented specimens of the Heloderma, Sphenodon, Dasypeltis and Protopterus.

THE following terse and vivid sketch appeared in last week's *Academy*, whence we borrow it. As a piece of descriptive writing, it should serve as a good example to many medical men, who, in noting mere scientific data, may often miss the human side of a case.

THINGS SEEN.

A HAPPY WOMAN.

The garden stood on the skirts of the village. It was enclosed by a high wall, and upon the wall stood a further bulwark of trellis-work. The room where I lodged overlooked the garden. My reflection, when I peeped from the window in the early morning, was: "There might a prisoner take exercise." Presently a lady, well-nourished, well-dressed, not ill to look upon, but not attractive—just the typical, well-preserved, hearty British woman, a little anxious about her weight, distressed periodically about by the heat—emerged from the house, talking rapidly in a high strident voice. Her manner was militant and restless. Clearly she had grievances, and since she chose to give them articulate form in her walled garden beneath my window, I smiled and left the room, for the day was fine and the wind temperate, and it was in my mind to sit beneath a tree with a book. When I returned, some hours later, she was still roaming about the garden—still talking. I listened, and smiled no more, for as I listened I learned that she was of those in whom the spirit sleeps, who know not what they are, who being alive are yet dead. Her madness took the form of Vanity. She believed that she was supremely beautiful; that the German Emperor loved her; that her picture was on the line at Burlington House; and that her singing and dancing excelled anything to be seen upon the London or Continental stage. Through all that summer day, through—for aught I know—every day of her healthy life (for the "touched" live long) that poor lady babbled of her loveliness to unheeding walls. Beautiful, rich, accomplished, beloved by a dashing monarch—these delusions were fixed ineradicably in her mind. They were her possessions, hers eternally. For the world outside her garden time would range, fruits fail, beauty fade; but she would remain always young, always beautiful, always the desired. Other things might change or wane, but the inviolable dimness of her mind—never.

We give of our pity to this demented lady who lives in a walled garden. We pity those in whom the spirit sleeps—but consider! She has all that half the world pines for and strives at great cost to gain. Do you want wealth? She has it. Love? Adoration? Applause? She has them all, and can never lose them—unless she recovers.

Resignation of Dr. J. F. W. Silk. Anæsthetist to Guy's Hospital.

WE have to record with sincere regret the resignation of Dr. Silk, who has been associated with the Dental School since its foundation in 1889.

For about two years after his appointment he attended on two mornings during the week, but subsequently on Thursdays only. Dr. Silk also held the position of Anæsthetist to the hospital for some years.

As a specialist in Anæsthetics he is widely known and appreciated, and it would be invidious on our part to dwell upon his acknowledged ability and skill. We may,

however, take this opportunity of stating that his clinics were always well attended, not only by dental men, but also by senior medical students. His demonstrations, too, in the lecture theatre were eagerly sought after, and much that was practical was learnt from them.

It was mainly due to Dr. Silk that the systematic teaching of anæsthetics was carried out at Guy's, and for some years past a house appointment has not been made unless the candidate produced a certificate to the effect that he had himself administered anæsthetics under the supervision of a hospital teacher.

Dr. Silk was probably the first to use the celluloid face-piece in the administration of nitrous oxide gas. This material, on account of its transparency, is now almost invariably employed in dental practice.

As a writer, Dr. Silk's work "A Manual of Nitrous Oxide Anæsthesia," is a valuable contribution to the literature of the subject, and he has also from time to time contributed papers to the "Society of Anæsthetists," "Guy's Hospital Reports," "Proceedings of the Odontological Society" (Observations on Bromide of Ethyl in Dental Surgery, with notes of 100 cases), the "Lancet," and our own paper.

We again express our regret at the loss of Dr. Silk's services, whilst we congratulate him upon the stress of private practice which has presumably necessitated it.

Nursing News.

The Editor of Guy's Hospital Gazette has most kindly given the contributor of "Nursing News" a holiday, otherwise this column would probably have contained a graphic account of the visit of some of the Nursing Staff to Marlborough House, and also of the Garden Parties so kindly given by Mr. and Mrs. Bonsor at Kingswood Warren, to the whole staff.

The Matron is enjoying her holiday in Scotland, and feeling all the better for the change and rest; we hope to welcome her back early next month. Some of the Sisters have had their holidays, and eight are away now. There are about twenty Nurses either on holiday, sick leave, or in the sick room.

Nurse M. C. Allen has been transferred from the Theatre to Job ward, in place of Nurse Thain, and Probationer Reed has been given her strings for the Theatre.

The subways from the Medical and Surgical Buildings to the Nurses' Dining-hall are again in use, so that Nurses no longer use the stairs by the Sisters' hall and Housekeeper's room, nor yet the College subway.

It has been arranged that those Nurses who are off duty in the afternoon, and like to go to Evensong at 5 p.m., may get tea in their hall at 4.45 p.m., instead of waiting till 5.20 or 5.25 p.m.

Correspondence.

The Editor cannot hold himself responsible for the opinions expressed or the advice tendered by Correspondents in the following letters.

To the Editor of Guy's Hospital Gazette.

Locum Tenens.

Sir,—The perennial and ever green question of the relations of Locum and General Practitioner is, I notice, again to the fore. To my mind the most striking feature of the case is the extraordinary alteration that a few years can make in a man.

As a locum, no man can be a gentleman. Many take morphia or drink to excess. As a rule they never have any decent clothes to wear. Few, if any, can behave at table, as they have never lived in a properly appointed house. The majority have never spoken to a lady in their lives, and all destroy the practice they go to take and for which they are paid so handsomely.

Yet once in a practice of their own, everything is altered. Their dress would become a Beau Brummel, and their manners are courtly in the extreme.

Having acted as a locum for some years, might I offer a few suggestions to Principals and Locums?

To the G. P.

1. Do not wait till the last day to obtain by wire a locum, as men who have done much of the work have all decided early in the year where they will go, and if the G. P. wants one at the last moment he must be content with what he can get.

2. For a well-qualified and experienced man a higher fee is naturally required, and if the practice contains such patients as "Lady Paywell," surely £4 4s. is not an exorbitant sum.

3. Let the G. P. take a locum from his own hospital and a man who is known there. If in doubt as to his locum, let him write to the Medical School Office, or to one of the School Staff, and find out who is to take his place.

4. The G. P. might remember that at times, strange though it may seem, the locum is more of a gentleman, is better qualified, and used to a better house table and society than he gets when taking some practices.

To the Locum.

1. Never go to a man who did not come from your own hospital.

2. Find out the G. P. whose practice you are to take. If he is any good he will be known. If not, don't go.

3. Find out who the previous locums have been and communicate with them, so that you may know what kind of place you are to go to.

Men who do much locum work go year after year to the same practice, and if the locum is being constantly changed, it is reasonable to suppose that the fault does not always lie with the locum.

Finally, locums should remember that the average G. P. is the most conceited man on earth and should be humoured accordingly.—I am, Sir, yours truly,

F.R.C.S.

Dear Sir,—In your last issue there appeared an amusing account of the genus Locum Tenens, in which the following sentence occurred:—"Locums as a class consider it *infra dig.* to dispense medicines, which generally resolves itself into the fact, that they don't know how to do so." Sir, as a Locum Tenens, I plead guilty to the latter indictment; but on behalf of nine-tenths of my class I wholly deny the former charge. The fact is, as the writer says, that we don't know how to dispense, and so we either fight shy of it, or we boldly set to work and learn it at the expense of our tempers and our patients, having plenteous recourse to the "Shake the Bottle" label.

The amount one learns about drugs in this way, even in a month, is amazing. Before leaving Guy's, even when you have done the chief appointments, prescribing, except by the Guy's Pharmacopœia, is a terror; after a month's dispensing it is as easy as arranging a set of lawn tennis among your friends. Formerly a drug was an abstract principle; now it is a concrete substance, represented at least by a bottle, a colour, a taste, or a smell.

There is no reason why men should not acquire this knowledge before leaving Guy's, if suitable arrangements were made; and such knowledge would be of immense use both for examinations and practice. As it is, house-physicians and clinicals have to order medicines on their own responsibility, clerks on that of others; and most clinicals and clerks would be only too glad to have the privilege and the diversion of making up their prescriptions. I should suggest, therefore, that the authorities, as a beginning, might provide a small dispensary of 100 bottles or so in Clinical, and that all medicines ordered by clinicals should be made up on the spot. Perhaps later it would be possible to extend this arrangement under suitable supervision and within limits to the Out-patient department.—Believe me, Sir, Yours truly,

FRANCIS E. FREMANTLE.

Dudley House, Kenilworth, August 9th.

Consideration of Patients.

Sir,—Surely with the recent advances of Surgery and Medicine it would be possible to give more thought to the patients. I give two instances:—

1. On the Surgical side—The patient, man, woman, or child, is always anæsthetised in the operating theatre, in the presence of numerous students and to the accompaniment of the clash of instruments and voices. Can the effect be beneficial, and can his or her remembrance be as pleasant as it might be? Why not use Coel's room for anæsthetising, and have the patient on a table with wheels? This is done both in London and the Provinces.

2. On the Medical side (and Surgical)—The children and women are always in the same wards; and it is by no means uncommon to find a poor woman dying, with the baby in the next cot squealing for all it is worth.

Patients come to the hospital to be well cared for and to be *comfortable*. They do not complain publicly, but a few minutes of careful observation will show what they *think*. Women may be used to crying infants when well, but that does not imply that they prefer it—and how much more do they notice any noise when dangerously ill.

The danger of infectious fevers is the chief argument against a children's ward—but there is no reason against moving a child that *will* cry to a small room which might hold four or five cots for such cases. Other hospitals do so, or have a ward for children, and why not Guy's?

At present every consideration is given to asepsis apparently to the exclusion of all other points. An operation does not end with aseptic pad, iodoform gauze, carbolic spray or chinosol—"After-treatment" is sometimes of more importance.—Yours,

WARD CLERK.

That Hat-band again.

Dear Sir,—In reference to various paragraphs in recent issues of the Gazette upon the subject of the Guy's hat-band, I should like to draw attention to the fact that the colours in question are those of the "Clubs' Union," and any member of the Union is entitled to wear those colours, without reference to the particular course of study which he is taking up.—I am, dear sir, yours faithfully,

J. KENNETH CLARK.

40, Killieser Avenue, Telford Park, S.W.

Pass List.

University of London, July, 1899.

Intermediate Examination in Medicine.

Examination for Honours.

Anatomy (Third Class).—W. H. Bowen.

Physiology and Histology (Second Class).—M. Coplans. (Third Class).—W. H. Bowen, A. E. H. Pakes, L. E. Stamm.

Materia Medica and Pharmaceutical Chemistry (Third Class).—W. H. Bowen.

Pass Examination.

Entire Examination (Second Division).—H. W. Brown, M. W. Cohen, J. T. Hicks, N. H. A. Houghton, W. G. Parker, C. H. Robertson, F. L. Thomas, A. H. E. Wall.

Excluding Physiology (Second Division).—J. Evans, D. S. Graves, H. K. Lacey, F. C. Wetherell.

Physiology only (Second Division).—M. A. Collins, W. J. Davies, A. C. H. Gray, W. M. Robson.

Intermediate Examination in Science and Preliminary Scientific Examination Conjointly.

Second Division.—H. H. Carter, J. H. Clatworthy, R. Felton, A. Leeming, M. G. Louisson, A. P. Piggot.

Intermediate Examination in Science.

E. H. B. Milsom.

Preliminary Scientific Examination.

Entire Examination.—Second Division.—Robert P. Rowlands, G. Russell.

Chemistry and Experimental Physics.—G. Hamilton, A. M. Roome.

Biology.—A. E. F. Kynaston, J. O. Musson, C. H. Reinhold, R. O. Williams.

Final Conjoint Examination, July, 1899.

Medicine and Surgery.—*H. R. H. Denny, *H. M. Reeve, *G. S. Simpson, *C. B. Thomson.

Medicine and Midwifery.—*W. R. Cazenove.

Surgery and Midwifery.—W. B. Secretan, D. P. Watson.

Medicine only.—*G. Beley, *V. T. C. Bent, T. W. S. Browne, H. W. Bruce, J. T. De Coteau, H. Durbridge, W. W. Harrison, *W. B. Hope, P. C. P. Ingram, *A. R. McLachlan, *C. D. Outred, E. E. Parrett, A. W. Penrose, *J. G. Taylor, *A. R. Thomas, *C. F. Watson.

Surgery only.—T. H. Body, *E. A. Evans, O. Marriott, R. C. Mullins, J. F. Northcott, J. S. Steele Perkins, W. G. Stewart, *J. B. Walters.

Midwifery only.—G. M. Brown, C. A. D. Bryan, E. Cohen, C. E. Hicks, H. C. Holden, L. H. Lewis, B. W. Moss, *S. A. Ruzzak, F. W. Ta Bois, *T. M. Walker.

* Denotes completion of examination.

First Conjoint Examination, July, 1899.

Part I.—Chemistry and Physics.—R. G. Anderson, F. Barnes, O. Black, L. Cooke, R. Franklin, H. B. German, H. N. Grose, W. T. P. Meade-King, G. Nunn, E. C. Peers, W. W. Read, R. M. Rendall, J. F. Rey, Richard P. Rowlands, M. B. Taylor, F. H. Wallace.

Part II.—Practical Pharmacy.—K. Black, J. B. C. Brockwell, F. Curtis, P. D. Hunter, A. C. Lewis, S. S. H. Shannon, F. W. Smith T. J. Wright.

Part III.—Elementary Biology.—P. C. V. Bent, H. M. Langdale, W. T. P. Meade-King, W. S. Orton, C. W. R. Preston, J. F. Rey, F. H. Wallace, C. A. Watson-Smyth.

(Four Years' Regulations.)

Part II.—Materia Medica.—B. Isaac.

On the Decline of Scurvy.

(Being a Paper read before the Hongkong Branch of the British Medical Association, February, 1899, by Surgeon C. Marsh Beadnell, R.N.

(*Concluded*)

Too much reliance should not be placed upon lime-juice in scurvy; there is no doubt but that the increase in the number of cases of this disease that obtained amongst merchant seamen after the compulsory administration of the remedy to every individual at sea for a period exceeding ten days was in part the result of the Merchant Shipping Act passed by Parliament in 1867. Those in authority over the crews pinned all their faith on this remedy, neglecting other and far more important articles of diet: instead of making use of a valuable medicine, a sad *abuse* was made of it. That this serious augmentation, which you will better appreciate by referring to Table 1, was not due to any proportional

TABLE I.

Shows the increase in cases of Scurvy amongst Merchant Seamen that occurred after the passing of the Lime Juice Act in 1867.

Year.	Number of Cases of Scurvy amongst Merchant Seamen.	Increase or Decrease compared with previous year.
1866	33	.....
1867	88	+55
1868	90	+ 2
1869	22	−68
1870	22	0
1871	34	+12
1872	40	+ 6
1873	19	−21
1874	30	+11
1875	57	+27
1876	69	+12
1877	80	+11
1878	84	+ 4
1879	93	+ 9
1880	92	− 1
1881	99	+ 7

increment in the number of merchant seamen is proved by an inspection of the returns for those years, for in 1878 there were 138,068 merchant seamen afloat, whereas in 1880 there were but 135,356, a diminution of over 2,700 men. The regulations of the Board of Trade now require that an adequate stock of antiscorbutic articles of diet be taken on board every vessel destined to be at sea for a period greater than ten days, and an outbreak of scurvy afloat nowadays would certainly lead to the indictment of the captain or owners of the vessel for criminal negligence: typical examples of such antiscorbutic *matériel* are, fresh meat, milk from grass-fed cows, and most of the esculent vegetables (the Leguminosæ, however, have little or no antiscorbutic value). Potatoes are very valuable in this respect. It has been computed that seven ounces of this vegetable equal in antiscorbutic value one ounce of lime-juice. Parkes attributes the

absence of scurvy at the present time in a great degree to the universal use of potatoes as an article of food, and certain it is that some of the most serious outbreaks of scurvy in Ireland have followed the potato famines. It suddenly increased after that terrible potato famine in 1846; again, in 1842 there was an outbreak of scurvy at the Millbank Penitentiary directly traceable to the cessation of potato allowance to the inmates. An outbreak of scurvy occurred in the Barracks of Rastatt in the winter of 1851 to 1852; the poor lived exclusively on soup, beef, and dumplings, potatoes being so scarce and dear.

In 1876 the sledging parties of the *Discovery* and *Alert* were much afflicted with scurvy. In the log it is stated that 'they had no lime-juice and but little potato since leaving their ships.' *Amchur*, a concoction made from the mango, was frequently administered to those sick of the disease. One ounce of this vegetable preparation is said to be as valuable as eight ounces of lime-juice. Red wines have been much used in Continental armies with the object of warding off scurvy; they owe their medicinal value to the bitartrate of Potassium.

In the Nile expedition of 1882 jam was issued to the men in a routine manner in order to prevent the onset of the malady; this delicacy contains the malates and citrates of Potassium.

To impress your minds with the good services that have been rendered by so unassuming a member of the vegetable kingdom as the domestic mustard and cress, allow me to quote a celebrated experiment made several years ago by James Haviland, an English surgeon in the Indian Mercantile Marine. This officer was in medical charge of the *Sir William Pultenay*, bound for India with contingents of soldiers and sailors. He served out the seeds of mustard and cress to his crew with injunctions to sow them on warm moist flannel in a light airy place, and to mix and partake of a small portion of the resulting plants with their ship's diet; these instructions were conscientiously obeyed with the issue that of all the vessels that arrived in India, but one was exempt from scurvy, and that one the *Sir William Pultenay*. Captain Cook, when in command of the *Resolution* and *Adventure*, provided sauer-kraut for his men as a prophylactic against scurvy; sauer-kraut, as most of you know, is the firm white central part of the red or green cabbage cut into slices, sprinkled with salt and some condiment, as pepper or juniper, and then placed between boards in a cask under *gentle* but constant pressure till fermentation ensues; Cook left Yarmouth, July 13th, 1772, with the object of ascertaining how far the lands of the Antartic stretched northwards; for this purpose he sailed round the edge of the ice and succeeded in penetrating the 71°10′ S. long. and 110°54′ W. lat. He returned to England and entered Plymouth, July 29th, 1775; thanks to his admirable forethought in providing the sauer-kraut there was during the whole three years but one death in his crew. Sir William Smart in a lecture delivered before the Royal College of Surgeons, in March, 1883, upon 'Scurvy' describes the intense desire for vegetable food experienced by himself and comrades when imprisoned in Lucknow during the siege; men risked their lives to obtain the small species of cruciferous plants that grew outside the walls, and which when obtained were esteemed of such value that they were sold to the besieged residents for their weight in silver; the plants were probably some of the several varieties of scurvy grass that have from time immemorial been used by voyagers and explorers as preventives of scurvy; those more frequently met with are: *Cochlearia officinalis*, the common or lemon scurvy grass, a favourite ingredient of salad dishes. *C. Coronopus*, wild scurvy grass, familiarly known as 'swine's cress.' *C. Anglica*, English scurvy grass, and *C. Armoracia*, the horse-radish.

At the time of the Crimean war, the soldiers found by experience that the consumption of small quantities of dandelion leaves kept them in good health and free from scurvy. Carnivorous animals, and those races of men who are chiefly flesh-consumers, frequently feel the desire for Potassium; who has not seen the domestic dog and cat, when out of sorts, eating grass? Kaffirs are known to greadily eat the semi-digested morsels of grass they find in the stomachs of cattle. Esquimaux have an instinctive appreciation of the medical value of the small quantities of grass they find in the stomach of the Musk Ox, every blade of which is providently stored up for future consumption. It is possible, however, to have too much of a good thing, even though that thing be Potassium. You remember I said awhile back that increased consumption of sodium chloride increases the *excretion* of Potassium salts, hustling, as it were, the latter out of the system. There is, therefore, a scientific basis for the popular notion that scurvy is the result of eating too much salt food. Well, the converse of this is also true. Potassium salts increase the excretion of Sodium salts. Between those salts containing no Chlorine (*e.g.*, Carbonates or Phosphates) and the Sodium Chloride in the blood a double decomposition takes place; thus, supposing Potassium Phosphate to have been administered, the following chemical changes ensue:—

K_2HPO_4	+	2NaCl	=	Na_2HPO_4	+	2KCl	
Potassium Phosphate		Sodium Chloride		Sodium Phosphate		Potassium Chloride	

These newly-formed salts are unnecessary for the organism and are expelled in the urine along with the unaltered remainder of the phosphate administered. Considerable quantities of Sodium and Chlorine may thus be removed from the organism, producing harmful results; in consequence of this, herbivorous animals and people who live chiefly on a vegetable diet (and thus consume enormous quantities of Potassium) feel the need of Sodium Chloride greatly. At meals one instinctively takes Sodium Chloride with vegetables. On the American prairies enormous herds of Buffalo travel hundreds of miles to visit the 'salt licks.' Vegetarians may escape scurvy, but they frequently suffer from symptoms of Potassium poisoning; they become languid and disinclined to take exercise, are incapable of pro-

longed thought, have a flabby, empty, slow pulse, and are frequently melancholic. Potassium we know is a powerful protoplasmic poison in any quantity approaching excess, paralyzing motor nerves and nerve centres, and bringing about a rapid fall in blood pressure and pulse rate.

It is a significant fact that the behaviour of Potassium and Sodium respectively towards the animal organism is almost the exact converse of their respective behaviour towards the vegetable organism. In the *Journal of the Chemical Society* for November, 1898, will be found an account of some manuring experiments made with salts of Potassium and Sodium by Messrs. Smets and Schreiber. These observers found that the presence of Sodium salts in manures had the remarkable effect of compelling the plant to take up an increased quantity of Potassium salts. Just as a tonic, judiciously administered to the invalid, increases his appetite and thus compels him to take in more nourishment, so does Sodium act towards the plant. Facts stated at intervals often lose the very significance they are intended to convey owing to the absence of contrast; I have, therefore, in the accompanying Table II., endeavoured to render them more striking by arranging them in tabular form. I need not remind you that the statements in the table but represent the usual order of the day; at every turn are we confronted with exceptions; we have plants possessed with the power of rapid locomotion, and animals that are born, live, and die on the same spot, we have plants that feed on the quivering flesh of animals they themselves have slaughtered, and animals that are content to build up their frames upon carbonic acid gas and salts; we have plants that love the darkness, and animals that sport in the sun, converting its kinetic energy into potential energy. Nature abhors, not a vacuum, but dogmatism. But I am wandering from my subject and must return. We were speaking just now of vegetable antiscorbutics, and I think this an opportune juncture to draw your attention to a point that has till recently been much disputed. Is meat antiscorbutic or no? Mr. Neale, of Arctic fame, says, 'If you live on the flesh of the country (Arctic) even without vegetables, you will run very little risk of scurvy.' Another authority says, 'Look at the Mohammedans, they are great meat eaters, yet seldom suffer from scurvy, whereas the Parboos (Hindoos), almost entirely vegetarian in habit, are commonly attacked. The Chinese again are a great vegetable-consuming nation and eat but little meat; they are, I believe, free from scurvy. In the year 1882 the *Adventure* was anchored in Port Famine for several months. The crew had abundance of pickles, cranberries, wild celery, tinned meats and soups, but no *fresh* meat. Early in July of that year scurvy broke out, but at the end of the month a large supply of fresh Guanaco meat was procured and the disease rapidly died out. Esquimaux seldom suffer from scurvy, yet are, owing to unavoidable circumstances, very carnivorous in their habits (that they do, however, occasionally suffer from this disease is proved by the writings of John Marshall, F.R.S., who says he 'cured them with lime-juice.') Up in Newfoundland, on the other hand, where the poor feed to a great extent upon salt fish, scurvy is extremely common.

TABLE II.

To show the main differences between a plant and an animal, and their respective reactions towards Potassium and Sodium.

Animal.	Vegetable.
1. Chief source of nutrition, Vegetable Kingdom.	1. Chief source of nutrition, Mineral Kingdom.
2. Excretes Nitrogen.	2. Does not excrete Nitrogen.
3. Active.	3. Passive.
4. Ingests solid food.	4. Ingests liquid food.
5. Inhales Oxygen.	5. Exhales Oxygen.
6. Cells show marked division of labour.	6. Cells show but little division of labour.
7. Contains no cellulose.	7. Contains cellulose.
8. Oxidizes Carbon compounds.	8. Reduces Carbon compounds.
9. Receives its Nitrogen from complex proteids.	9. Receives its Nitrogen from simple Nitrates.
10. Katabolic.	10. Anabolic.
11. Lives at high chemical pressure.	11. Lives at a low chemical pressure.
12. Exhales Carbon dioxide.	12. Inhales Carbon dioxide.
13. Cells not walled.	13. Cells walled.
14. Contains no Chlorophyll.	14. Contains Chlorophyll.
15. Converts potential energy of complex molecules into kinetic energy of locomotion.	15. Converts kinetic energy of sunlight into potential energy of complex molecules.
16. Potassium is important.	16. Potassium is very important.
17. Potassium in excess causes an undue *ex*cretion of Sodium.	17. Potassium in excess causes an undue *se*cretion of Sodium.
18. Potassium in poisonous quantities causes melancholia, paralysis and death.	18. Potassium in poisonous quantities causes death.
19. Potassium absent, scurvy results, and symptoms of poisoning by Sodium.	19. Potassium absent, death ensues.
20. Sodium is very important.	20. Sodium is important.
21. Sodium in excess causes an undue *ex*cretion of Potassium.	21. Sodium in excess causes an undue *se*cretion of Potassium
22. Sodium in poisonous quantities causes delirium, convulsions, and death.*	22. Sodium in poisonous quantities causes death.
23. Sodium absent, symptoms of poisoning by Potassium.	23. Sodium absent, disease ensues owing to the plant being unable to secrete sufficient Potassium.

* *Vide* accounts of shipwrecked sailors dying of thirst and drinking sea water.

Dr. A. Marrion, in his work entitled 'Medical History of the French Fleet,' remarks that compressed vegetables were used in the French Fleet and found to be useless, for the disease attacked six ships of the fleet, *laying low 1,000 men*, no amelioration eventuating till a supply of fresh vegetables was obtained. (No doubt during the process of compression, the salts to which the fresh vegetables owe their anti-scorbutic properties are expelled with the juices of the plants). Aitken says he met with one of his worst cases of scurvy in private practice. It occurred in the person of a man who had been living almost exclusively upon roast mutton and bread; he was speedily cured by vegetables.

I think I have quoted enough examples to show you that tropical and arctic experience is very much at variance with that acquired in Europe, the former claiming meat as a valuable antiscorbutic, the latter discarding it as worthless. Which side is justified in its statement? Either or neither, according to the way one looks at it. Remember that blood, when fresh, is markedly alkaline in reaction, its alkalinity being in part due to the alkaline carbonates derived from the malates, citrates, etc., of the vegetable food-stuffs. Scurvy is due to the absence, or rather I should say, diminution of these salts in the *liquor sanguinis* whereby the latter more nearly approximates an acid reaction (though never arriving at a condition of complete acidity in the living organism). Now fresh meat, that is to say, flesh from a recently slaughtered animal, is alkaline, but *hung* meat is neutral, or even acid in reaction. In hot climates the flesh is eaten so soon after the death of the animal that time is not allowed for acidity to develope; again, in arctic zones the very low temperatures that there prevail suffice to check the chemical changes necessary for the production of acidity. The acidity of hung meat is due to acid phosphates (KH_2PO_4,) the alkalinity of fresh meat to alkaline phosphates (K_2HPO_4). When an animal is slaughtered, its muscles (meat) pass into the state called cadaveric rigidity or rigor mortis, on the culmination of which Lactic acid is developed, the latter immediately attacking the alkaline phosphate converting it into the acid salt.

$C_3H_6O_3$	+	K_2HPO_4	=	KC_3H_5O	+	KH_2PO_4.
Lactic acid		Alkaline Potassium Phosphate		Potassium lactate		Acid Potassium Phosphate

Thus we see that in both very hot or very cold regions the meat is consumed in an alkaline condition, and being thus charged with alkaline salts possesses high antiscorbutic properties, but in temperate Europe we generally keep our meat for some time prior to consumption, time is thus given for the development of acidity, to the great detriment of its antiscorbutic value; in this way, I think, the above discrepancies are reconciled.

Scurvy has at times been observed to display the most singular caprice, attacking those on shore whilst ignoring those afloat. In 1884 this disease was rife amongst the Russian sailors ashore, those at sea escaping. The Russian medical officer throws out the suggestion that this curious state of affairs was probably owing to the fact that the ration of meat at sea was double that on shore. A somewhat similar circumstance occurred in our own fleet in 1759 and 1760, the Channel Squadron of which was then some eight months at sea under the command of Sir E. Hawke, enjoying excellent health the whole time, because kept supplied with fresh beef and vegetables sent out to them in tenders, but at this same time scurvy was raging at the Naval Hospital, Haslar, several succumbing to the malady, the disease not abating till the beginning of 1761.

Scurvy, like a grim spectre, has always followed closely in the wake of wars, famines, and pestilences; after the siege of Paris in 1871 it broke out in epidemic fashion; the wars of Ferdinand II. with the Saracens were invariably linked with scurvy; the bad harvests that occurred at the beginning of the century in the eastern provinces of Russia were succeeded in proximate years by the most piteous ravages from this disease, the disease selecting with malignant accuracy those provinces (*e.g.* Perrm) in which the deterioration of the crops was most marked.

TABLE III.

YEARLY ADMISSIONS OF SCURVY TO SEAMEN'S HOSPITAL, GREENWICH.

Year.	Cases.	Increase or decrease compared with previous year.	Year.	Cases.	Increase or decrease compared with previous year.
1840	36	...	1869	30	−33
1841	55	+19	1870	30	0
1842	82	+27	1871	24	− 6
1843	67	−15	1872	30	+ 6
1844	49	−18	1873	8	−22
1845	85	+36	1874	29	+21
1846	75	−10	1875	15	−14
1847	85	+10	1876	30	+15
1848	36	−49	1877	25	− 5
1849	17	−19	1878	30	+ 5
1850	54	+37	1879	19	−11
1851	57	+ 3	1880	46	+27
1852	52	− 5	1881	34	−12
1853	64	+12	1882	28	− 6
1854	128	+64	1883	15	−13
1855	130	+ 2	1884	7	− 8
1856	90	−40	1885	8	+ 1
1857	72	−18	1886	5	− 3
1858	77	+ 5	1887	12	+ 7
1859	90	+13	1888	10	− 2
1860	76	−14	1889	2	− 8
1861	100	+24	1890	3	+ 1
1862	65	−35	1891	4	+ 1
1863	85	+20	1892	0	− 4
1864	76	− 9	1893	3	+ 3
1865	99	+23	1894	1	− 2
1866	91	− 8	1895	0	− 1
1867	90	− 1	1896	3	+ 3
1868	63	−27	1897	0	− 3

The very satisfactory attenuation of scurvy amongst sailors generally, and amongst those of the Navy es-

pecially, I have endeavoured to show in Table III. The figures represent the number of cases of this disease annually admitted to the Seamen's Hospital, Greenwich, between the years 1840 and 1897. Up to the year 1879 the cases were mixed, some being from the Navy, others from the Merchant service, but no case of scurvy in a Naval Seaman has been admitted to the Seamen's Hospital since 1879, most of the cases admitted since that date occurring in the persons of young Norwegian sailors.*

If we take the mean of the annual admissions prior to the passing of the Lime Juice Act and compare it with the mean of annual admissions after the Act we find the former to be 4·3 times the latter. From 1840 to 1866 the mean annual admission was 74. From 1866 to 1896 it was 1·72.

And now, gentlemen, that you have been so kind as to accompany me thus far, I would ask you as a final request to glance back into the times past and contemplate the extravagent waste of life that has to be laid at the door of this fell disease; conjure up the vision of Anson leaving England in September, 1740, with six vessels and 800 men, returning to Spithead four years later with 350 men lost by scurvy. I am tempted to ask you to compare two trips practically identical as regards locality and distance, but the one made some 400 years prior to the other. Vasco da Gama left Lisbon, July 8th, 1497, with 160 men, 100 of whom were down with scurvy before rounding the Cape; they had no lime-juice; H.M.S. *Powerful* left Las Palmas, October 15th, 1897, with a complement of 1090 men and arrived at the Cape, October 30th. The total quantity of lime-juice consumed during these fifteen days was 8175 ounces; needless to say, there was no scurvy. Again, think of Magalheins, the great Spanish navigator, leaving San Lucar, August 10th, 1519, with 234 men, crossing the mouth of the Rio Plata, coasting the shores of Patagonia, threading the straits which now bear his name, crossing the vast Pacific and reaching the Philippine islands only to be killed in an encounter with the natives of Matan, his vessel having to be piloted home by Sebastian del Cano, completing on September 6th, 1522, the first voyage round the world—but with what a sacrifice! Only thirteen of the original 234 men returned to tell the tale, scurvy having to answer for the majority of those dead. Compare this with Nansen's recent Arctic voyage in the *Fram*, completed without a death from this disease. In one of the back numbers of the *British Medical Journal* I find an account of the arrival at Bristol of a barque, the *Agartha*, from South Carolina, with nearly all hands below decks sick of scurvy, the vessel having been navigated on her homeward voyage by the captain and two seamen. Remember that this disease wrought more havoc amongst soldiers and sailors in war time than did the sword; in the Crimean war 23,000 cases of scurvy developed in the French army alone, and in all the naval battles of the Seven Years' War there were but 1512 sailors and marines killed by implements of war, yet 133,708 men died of disease or were missing, *the principal disease being scurvy*. One might, with ease, multiply such instances, but I think enough has been said to enable us to fully appreciate the great and everlasting boon conferred on our sailors and marines by those pioneers of naval hygiene, foremost of whom stands the immortal Gilbert Blane.

* I am indebted to the Secretary of the Seamen's Hospital for these figures.

In Lighter Vein.

Last week the Thames gave up its dead, and the police brought her into the Front Surgery. She had been in the water a long time, and p.-m. degeneration was very far advanced. Next day an inquest was held, and the twelve good men and true viewed the body with more than usually bated breath. The constable gave his evidence and the coroner put the usual question, "Has anybody any questions to ask the officer?" Then arose one of the twelve who had viewed the exceedingly dead body with the rest, and being full of new wine, spoke thus, "All I 'as to say is this: if she 'aint dead, or 'as the appearance of not bein' dead, she ought to be locked up." Then they led him by the hand into the cool air outside, and the subsequent proceedings were left to the eleven.

Mr. Stanley Cock has given up the delicate art of drawing teeth (no offence) and has settled down to the yet more delicate art of drawing caricatures. Specimens of his work may be seen weekly in our well-groomed contemporary "Table Talk." "The Medico," by-the-bye, will be forthcoming in October at latest—if not subsequently. We have seen the cover.

I publish the following letter with all due reserve. It is addressed to the

"House Surgeon
Of Guy's Hostpail."

"Sir

I write to your particulars in the answere to John Robert Hume according to his complaint he as suffer from a year and eight month from chicken-Pox and since he has been a envalided. He is Suffering from the large of the heart and bronchit and imfamation of the lungs and very bad cough. And his brother is heathly and Sister is the healthey and father life never had a day illness in his life strong and healthey man and I enclose with you

"And etc
"THOMAS HUME."

Two patients were making their toilets in the Surgical room, Front Surgery. "Mate," said the one, politely, "help us on with this coat!"

"Right oh!" replied the other, glad to assist a brother in distress. Having donned the coat, the first man thanked his unknown friend, and departed. Then the second man returned to his toilet; he took up the coat and was about to put it on when he noticed a strangeness about it. "Why," he exclaimed, "this aint my coat. That other fellow must have got mine by mistake. Why, strewthamighty, if 'e aint pinched my bloomin' clock. Well, lets see what 'e's left in *'is* pockets. Gawd! two dead rats and a rabbit skin!" Then he started off in pursuit of his friend, but whether he caught him or no the police records relate not. If he did, the case was probably settled out of court.

The Editor tells me that the subject of locums is being discussed in another part of the paper. The G. P. is not the only man who has to put up with a locum. However, list and learn.

The telephone bell rings in Clinical and is duly answered.

1st voice.—Are you there?
2nd voice (Clinical).—Yes.
1st voice (*louder*).—Are you *there?*
2nd voice.—Yes!!
1st voice.—Oh, did you ring?
2nd voice.—Yes, I answered you. Did'nt you ring?
1st voice.—Yes, 'oo are you?
2nd voice.—I'm Clinical. What do you want?
1st voice.—What?
2nd voice.—*What do you want?*
1st voice.—Would you mind repeatin' it, there's rather a lot of traffic.
2nd voice.—What the——what do you want?
1st voice.—Are you Clinical?
2nd voice.—Yes, how many more times?
1st voice.—Eh?
2nd voice.—Yes, I'm Clinical.
1st voice.—Are you there?
2nd voice.—Where the blue blazes do you suppose I am?
1st voice.—Well, is Mr. X in Mary?
2nd voice.—How the devil do I know?
1st voice.—Ain't you Clinical?
2nd voice.—Yes.
1st voice.—Do you know if Mr. X is in Mary?
2nd voice.—No.
1st voice.—What?
2nd voice.—No!!!
1st voice.—Would you mind repeating it? There's rather a lot of noise going on.
2nd voice.—No, I don't know where he is. Why don't you telephone on to Mary?
1st voice.—Aint 'e in Clinical?
2nd voice.—No, I've told you he isn't.
1st voice.—Well, there's two or three cases wants to see him in the surgery.
2nd voice.—I can't help that, he isn't here.
1st voice.—Oh, all right.

Rings off. A minute later bell rings in Clinical again.

1st voice.—Are you there?
2nd voice.—Yes.
1st voice.—Did you ring.
2nd voice.—No.
1st voice.—Oh, all right, is Mr. X in Clinical.
2nd voice.—No.
1st voice.—Oh, aint 'e? All right. Will you tell 'im there's two or three cases wants 'im in the surgery.
2nd voice.—I tell you he's not here.
1st voice.—Aint 'e? Well that was what I understood 'em to say.

Rings off, and Mr. X, who is in Mary Ward all the time is left in complete ignorance of the "two or three cases wanting to see him in the surgery."

A.

Sport.

The 220 Cup.

The Summer Session just over has been rendered noteworthy, or the reverse, by the conspicuous failure of Guy's in the Inter-Hospital Competitions. One trophy only fell to our lot (through the agency of F. W. Sime) at the Inter-Hospital Sports, and beside retaining the Cycling Shield we have nothing whatever to show for all the multitude of hours spent at Honor Oak Park by Guy's men. The Cricket, Tennis, and Water Polo Cups, together with the Athletic Shield, all seem as far off as ever. In the opinion of our groundman, the cricket team was the poorest that has represented Guy's for many years, the bowling being lamentably weak. No one expected the Athletic Team to do anything noteworthy, and it came fully up to expectation. The same applies to Tennis, only a little less forcibly, while the Water Polo Team was the only one to make really any fight for the Cup. And all this tale of disaster is rendered so much more woeful when it is remembered that Guy's men have far more advantages than most hospital students for excelling in all manly sports. Not the least of these is the whole-hearted encouragement given to them by the various members of the Staff, and we know personally that one of our surgeons feels the lack of keenness in the department over which he is President, very deeply indeed. To our mind, too, these results are unaccountable. Will anyone help us to the solution of the problem?

We give this week a representation of the only athletic Cup we hold, that for the 220 yards. Not, we hope, as an obituary notice, but as a danger signal to the junior men against the slough of slackness into which the hospital's athletics seem in imminent peril of falling.

Guy's Hospital Lawn Tennis Club.

GUY'S v. WANSTEAD.

Played at Honor Oak Park on Saturday, July 29th, and resulted in a lose for the Hospital by 7 matches to 1, one match drawn.

THE COMPETITIONS.—The Single Handicap.

The finals were played at Honor Oak Park on Wednesday, July 26th, when V. M. Wallis (received 15) met B. H. Wedd (received 2/6–15). As was to be expected, Wedd won rather easily (6–0, 6–3, 6–3). Wedd plays with great judgment, he knows when to play up at the net where it is very safe. He is steady, but hits hard at times. His opponent plays a good game from the back line, some of his drives being very hard and low.

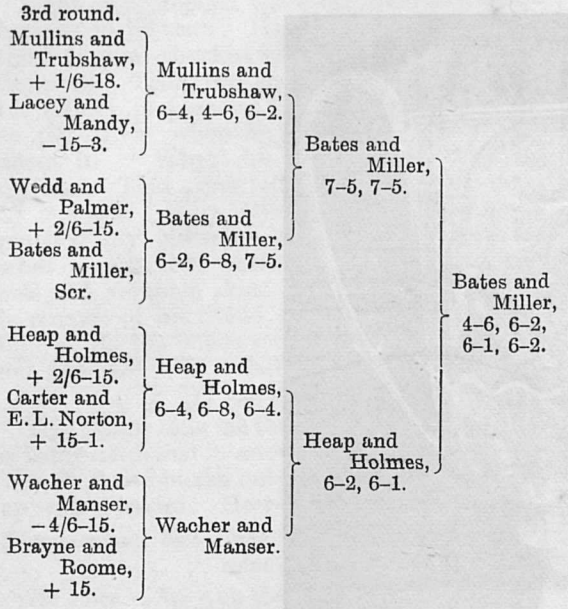
The winner met G. T. Willan in the semi-final, Willan owed 4/6–15 and got beaten, 6–0, 6–4. Wedd also knocked out Mandy (owe 30) 6–1, 6–1.

Wallis, on the other hand, had a hard struggle all the way up, beating Heap (receiving 3/6 15) 6–3, 2–6, 6–2, then P. J. Nash (receiving 15–2), 8–6, 3–6, 6–0, E. L. Norton (receiving 15–1), 1–6, 6–4, 6–1, W. B. Secretan (receiving 3/6–15), 9–7, 6–2, and in the semi-final E. N. Jupp the holder of the Lane-Washbourn Championship Cup (owe 15–2), by 3–6, 6–1, 7–5. All these three set matches point to good level handicapping, and the Committee must be congratulated on the result.

The Double Handicap.

This is the first time this competition has been tried, and its success this year will, we hope, lead to its being one of the regular competitions.

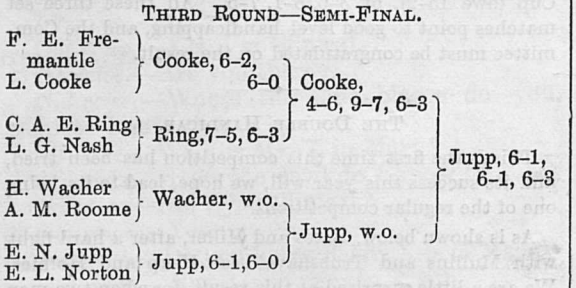
As is shown below, Bates and Miller, after a hard fight with Mullins and Trubshaw, beat Heap and Holmes. We are a little surprised at this result, for when two men play up at the net they should have no difficulty in out placing a couple, one member of which plays up at the net with his partner on the back line. Bates is certainly safe at the back of the court, and Miller at times good in the net, but we cannot help thinking that the "runners up" should have beaten them, especially after their experience in the Second VI. matches.



THE CHAMPIONSHIP.

There was a fair entry in this competition, but the results were unsatisfactory in that so many men scratched. In the first round Ransford beat Lacey, 2-6, 6–2, 6–4, but subsequently scratched to Roome. The other rounds are given below. In the final, Jupp easily beat Cooke. The game was only fairly good. Jupp's style was a little too cramped when playing a single, whilst Cooke, on the other hand, was too free. Jupp is very sure when playing up at the net, but Cooke was driving better than Jupp.

In the Championship round, the holder, P. S. Mandy, was evidently unfit, and Jupp had a fairly easy time, winning 3 sets to 1—6–4, 4–6, 6–3, 6–3.



Championship Round.

E. N. Jupp (challenger) beat P. S. Mandy (holder), 6–4, 4–6, 6–3, 6–3.

The tennis courts will now be open for lady visitors every week-day but Wednesday and Saturday, but each member and his visitors must restrict themselves to one court.

Solution to Case for Diagnosis, page 359.

Brain.—The convolutions on the right side were somewhat flattened, and the right lateral ventricle was distended by a clot the size of an orange; there was clot also in the left lateral and the third and fourth ventricles, and some blood had escaped through the roof of the fourth ventricle into the subarachnoid space. The source of the bleeding was not determined; the brain substance around the right lateral ventricle was somewhat ploughed up, elsewhere it was only compressed.

Heart.—There were some old and recent vegetations on the mitral valves which were stenosed. The aortic valves were healthy.

Appointments.

CIVIL.

Brown, W. S., M.R.C.S., L.S.A., has been appointed an Official Visitor to the Hospital for the Insane, Parramatta, New South Wales, *vice* G. H. Phillips.

Rice, David, L.R.C.P. Lond., M.R.C.S., has been appointed Assistant Medical Officer to the County Asylum, Cheddleton, Leek, Staffordshire.

Still, G. F., M.A., M.D., M.R.C.P., has been appointed Assistant Physician for Diseases of Children at King's College Hospital, London.

Tubby, Alfred H., M.S., F.R.C.S., has been appointed Surgeon to In-Patients at the Westminster Hospital, *vice* Thomas Bond.

Way, Montagu H., L.R.C.P. Lond., M.R.C.S., has been appointed House-Surgeon to the Royal Portsmouth Hospital.

NAVAL AND MILITARY.

Surgeon Bankart, M.V.O., R.N., has been appointed to the *Duke of Wellington*, for disposal.

Lieut.-Colonel H. J. W. Barrow, R.A.M.C., has been appointed officiating Principal Medical Officer to the Sirhind District.

Major C. S. Spong, D.S.O., R.A.M.C., retires from the Service, receiving a gratuity.

1st Volunteer Battalion the Sherwood Foresters (Derbyshire Regiment): Surgeon-Lieutenant R. H. Luce, F.R.C.S., to be Surgeon-Captain.

Births.

PEAKE.—On August 4th, at The Limes, Marden, Kent, the wife of W. H. Peake, M.D., B.S. Durh., of a son.

THOMAS.—On July 22nd, at Priory Cottage, Bushey Heath, Herts, the wife of J. D. Thomas, B.A., M.B., B.C. (Cantab.), of a daughter.

Ed.—H. L. E.

Contents.

	PAGE
ALCOHOLIC INSANITY: Clinical Lecture by Dr. Savage ...	353-362
NURSING NOTES	362
PASSIM	363-364
HOSPITAL NEWS	364-367
CORRESPONDENCE: Locum Tenens	367
NURSING NEWS	367
DR. PYE-SMITH'S LAST VISIT	368
REVIEWS	369-371
FROM THE GAZETTE'S SPECIAL PATHOLOGIST	371
IN LIGHTER VEIN	371-372

Notice.

All Communications, Articles, Letters, Notices, and Books for Review, should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well a subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

The charge for binding in blue, with the Arms of the Hospital in gold will be ONE SHILLING AND SIXPENCE.

Calendar of Coming Events.

September, 1899.

Sat. 9.—Messrs. Lucas and Lane's take-in; Drs., F. G. Cross and F. G. Gibson; Cl., F. O. Stoehr.

Sat. 9.—October Appointment list closes.

Mon. 11.—Names of Candidates for Entrance Scholarships to be sent to Medical School Office by this date.
Second M.B. Durham Examination begins.
Revision Classes for L.D.S. Eng. begins.

Tues. 12.—Application to the Medical School Office for Schedules for First and Second Conjoint Exams. to be made not later than this date.

Thur. 14.—Messrs. Golding-Bird and Dunn's take-in; Drs., H. McD. Parrott and T. R. Beale-Browne; Cl., D. P. Watson.

Fri. 15.—Last day for sending in Fees and Certificates for Camb. D.P.H. Exam.

Sat. 16.—Hos.-Sch. C.C.—Lilies, away.

Mon. 18.—Third and Final M.D. Durh. Exam. begins.

Tues. 19.—Schedules for Final Conjoint Exam. to be left at the Medical School Office not later than this date.

Thur. 21.—Messrs. Howse and Jacobson's take-in; Drs., P. S. Mandy and A. Moon; Cl., A. A. Miller.

Sat. 23.—Hos.-Sch. C.C.—Lilies, home.

Guy's Hospital Gazette,

SEPTEMBER 9, 1899.

Alcoholic Insanity.*

CLINICAL LECTURE BY DR. SAVAGE.

Delivered at Bethlem Royal Asylum, June 13th, 1899.

GENTLEMEN,—Last week we took for consideration the subject of general paralysis of the insane, although we could not exhaust the subject in a single clinical lecture. The subject which I propose to take to-day is allied to it in many respects. I have so often told you that it ought to be well registered by now, that every symptom of general paralysis of the insane is represented by degrees of alcoholism. Therefore it seems quite fit that we should next examine the symptoms of alcoholism and alcoholic insanity. First of all, it is convenient to point out some conditions which may give rise to what is unsoundness of mind apart from insanity. There is a great deal of unsoundness of mind that cannot be treated as insanity, and yet the person affected is temporarily beside himself. Such is the condition, and difficulty arises because so many forms of alcoholic disorder are very like the early stages of general paralysis of the insane. For instance, yesterday I was summoned in all haste to a flat in South-West London under these circumstances. A young naval officer of twenty-three, who had married not very long ago a very excitable and attractive-looking woman, had given himself up to debauchery and drink. He had taken large quantities of brandies and whiskies and sodas, as well as champagne and beer, and, indeed, had drunk anything which came in his way. Two nights before I saw him he said, "I am going to kill myself," and, in a half-fuddled, emotional condition, he seized a knife and drew the blunt back of it across his throat. That was taken away from him. Then he said, "I shall do it still," and with tears and general emotional disorder, he produced a knife from his pocket and very deliberately proceeded to open the blade. Of course, this also was removed. Then he said he should throw himself out of window, and when his wife came to soothe him, he said, "Do you not think we had better die together?" Here is a case of acute alcoholism, passing into alcoholic mania, or possibly only into delirium tremens. He is suffering from unsoundness of mind, and I could not tell at present whether he is going to have delirium tremens or acute delirious mania. Remember, anything which will produce delirium may produce mania. There is no hard dividing line between delirious

*Reproduced, by permission, from the *Clinical Journal*, August 30th.

conditions and maniacal states. Take an example suitable for the present time. A man at Epsom races won a considerable amount of money. He had been taking more whisky and brandy than was good for him before, and with his joy he drank half a bottle of whisky and became delirious, and after the delirium he became maniacal, and I was asked to see him in a condition very nearly allied to delirium tremens, except that it was more lasting and chronic. This state had gone on for some days with restlessness, sleeplessness, and general anorexia, besides sensory hallucinations, not quite of the typical terrifying form, but still of seeing people here and there, people interfering with him. All these symptoms were the symptoms of delirium, and had passed from simple delirium tremens on to mania, which lasted six or eight weeks. The man was fed well, kept quiet, freely purged, and thus got well. One has seen something similar follow the accidental taking of a drug like belladonna; and the use of a drug like chloroform or ether may start delirium which passes into mania. Now it is well, I say, to recognise that the symptoms produced by alcohol resemble those produced by general paralysis of the insane. The same parts are affected, and in the same order. The alcoholic poison affects the higher intellectual centres and defective control results, and, as I told you, the earliest symptoms of general paralysis are often hysterical and emotional and sentimental, so those of alcoholic insanity may be similar. Such was the case with the man of whom I was speaking just now, who talked about cutting his throat, about jumping out of the window, and who suggested to his wife that they should die together; he was in a highly sentimental condition, the result of alcoholism. Then, as a result of alcohol and with progressive defect of brain dependent upon degeneration in general paralysis of the insane, you get loss of power, a loss not only of the higher mental control but of the physical control. In general paralysis you get muscular tremor, as I have pointed out, but you rarely get the tremors so well marked early in general paralysis as you do in alcoholism. In alcoholism you get tremor of the tongue and of the lips, of the hands, and a hesitating gait; which is often more clearly marked in alcoholism than in general paralysis of the insane. Then there is instability, "to one thing constant never," though with alcohol you do not often meet with the same universally benevolent grandeur. Occasionally the alcoholic is benevolent, giving away what does not belong to him, but as a rule he is not so benevolent as the general paralytic. Then with alcoholism there is a defective memory for recent events, and there is also a spirit of make-believe, to which I shall have to refer later, as this is more characteristic of the temporary dissolution produced by alcohol than of the more coarse degeneration of general paralysis. The general paralytic is quite willing to tell tales and to make romances, but the alcoholic is more filthy in his tales. It is well to remember that though in the alcoholic, dissolution is apparently more marked than in the general paralytic, the alcoholic may get well. Remember, in fact, one of my favourite maxims is, "To the alcoholic all things are possible." I scarcely ever condemn a person, however bad he or she may be physically, as incurable, if there be a distinct history of alcoholism. I always think of being called down into Surrey to see a man, and when I looked at him lying on his back breathing stertorously, perfectly unconscious, and when further examination showed that he had bedsores, ulceration of one heel, I thought him sinking, and I said to the general practitioner, "Well, could they not let him die without my permission?" He said, "No, the friends thought they would like you to see him before he went." He told me the history, and I said, "Well, of course, it looks to me as if he is going to die, but to the alcoholic all things are possible." Four months afterwards a man tottered into my consulting room between two sticks. He said, "You do not remember me?" I said, "No." He said, "To the alcoholic all things are possible." I said, "You did not remember that?" He said, "No, but I was told when you were called in to see me die that you said, 'To the alcoholic all things are possible.'" He said, "Do you think it is possible for me to return as sporting editor to a certain sporting paper?" I said, "Well, it is possible but not advisable." I never heard of that gentleman since, but it is a very good example of what I refer to.

I will read the notes of the next case. His age is twenty-five, and he is a Hebrew. He has never been confined in an asylum before, but he is supposed to be alcoholic. There is no history of any neuroses in the family, and I am told there is no history of alcohol in the family. You know that alcoholics are supposed to beget alcoholics. One can go one step further, and say the alcoholic frequently produces degenerate offspring, the degeneracy being more commonly seen along the nervous lines. So that you get as a result of alcoholism a tendency to weak-mindedness, to idiocy, and to imbecility; in

children you get a tendency to convulsive seizures, to epilepsy, with arrest of mental development. There is also a tendency to defect in the higher control, a defective power of adjustment to surroundings, which means in many cases criminality in the offspring of alcoholics. There is intolerance of suffering and pain of all kinds, and instability, which means in many of these cases the so-called inheritance of a drink tendency. The child, however, does not inherit a love of alcohol, but inherits an inability to resist temptation, so that if he finds satisfaction in stimulants he takes them. It is a weakness which he inherits rather than any definite or direct tendency to vice. In our present patient there seems to be no inheritance of either alcoholism or insanity. It is to be remembered that the alcoholic—the person who tends to drink—is often not only a descendant of an insane parent, but he is also not infrequently the offspring of a degenerate parent, that is to say of a parent who is tending to nerve-decay, or is, from senile changes, degenerating generally. This particular individual is said to have been nervous, and hot-tempered. He had convulsions with teething. He is said to have had meningitis when a child. The patient has been intemperate for two or three years, and has had two or three attacks of excitement after drinking. About six months ago he fell on his head. Of course that is a noteworthy point. A person who falls on his head not infrequently becomes more susceptible to the influence of drink than another. And, again quoting myself, a man who is drunk, has drunk, and has been drinking, has got his nervous system into such a condition that a blow on the sodden brain is much more likely to cause degeneracy than a blow on a brain that has not been already so injured by alcohol. It is a fact, as I pointed out to you, that in the majority of cases of injury given as a cause in general paralysis associated with syphilis, it is an injury which acts on a brain which is already disordered in its nutrition by syphilitic arteries. When the patient was admitted this year, in April, he said his flesh was falling away from his body, that his brain was shrinking away, and that he was rapidly losing flesh and sinking. At the same time he was much excited; before admission he was always taking drugs, and at times he was very much depressed, threatened the lives of his father, mother, and sisters, and more especially threatened his father. He was very violent at times. At first he was sleepless and restless. He was afraid to close his eyes, spent the evening away from home, and came back in a very excited condition, but he denied having taken any drink on such occasions. Later he began to say that he was wasting away and could see his flesh going, but notwithstanding that he ate ravenously, and since admission he has been excited and restless. He said he was so ill that it was a sin not to send him to the hospital. It seems that he had neither hallucinations of sight, hearing, or taste, but he said he felt there was a lot of blood in the left side of his head, and he felt somewhat peculiar there. Sight was apparently normal, the pupils were normal and equal, reacting to light and accommodation. The speech was rather thick, but there was no difficulty about it. His dreams were unpleasant and his memory uncertain. On admission he was suffering from hypochondriacal melancholia.

We will now see the patient and verify the symptoms as far as we can. Unfortunately the most interesting of these cases are like landscapes or rainbows—more easily seen than demonstrated. A case is brought into hospital suffering from acute alcoholism or insanity depending upon acute alcoholism, and in a very few days the whole symptoms pass off. And this I would say in parenthesis. If I am asked to see an alcoholic patient, however violent and however threatening—once more I refer to our naval officer whom I saw yesterday—I hesitate to certify to his insanity. In that case I was called down in all haste and was asked to bring "urgency papers" with me, so as to send him to an asylum at once because he threatened suicide, because he attempted to jump out of window, because he suggested to his wife that they should kill themselves together. It is all very well, but I am not going to sign a certificate for a patient suffering only from acute alcoholism. What would be the result? You send a patient into an asylum. In forty-eight hours he is better; at the end of a week he is so far well as to recognise where he is and what you have done, but not sufficiently well to be grateful for what you have done. The only people who have ever prosecuted me legally for having a hand in their detention in Bethlem or in their removal to asylums have been people suffering in that way. They say, "Well, I never was insane, there was nothing wrong with me." I will give you a good example. A man pursued me when I was superintendent at Bethlem as far as the House of Lords. He got beyond that even, for when he ceased to be able to trouble me directly he used to get me subpœnaed to county courts to give evidence that at a certain time he was in Bethlem Hospital,

supposed to be unable to manage his affairs, and therefore irresponsible for debts that were then in question. He was admitted into Bethlem Hospital with ideas that his body was all wrong, that people were against him, with delusions that his employer—a barrister—was against him. He made up his mind that there was only one way out of it, and that was to kill the whole of his family and then destroy himself; and he thoughtfully prepared the epitaph which was to be put over his grave, and prepared a report which was to be given to the coroner. He provided himself with a revolver, and loaded it, a very dangerous bludgeon, and a long bowie knife, as well as some well recognised poison, also a bottle of less recognised poison, in the shape of bad whisky. On the strength of all these facts, and of his having interfered with his employer, he was taken before a magistrate, and, by experts, sent to Bethlem Hospital. In the course of a week or ten days he was very nearly well. I promised him to go to the convalescent establishment and he improved further. But no sooner had he got his discharge than he began at once to take up every action that he could possibly start—first against his employer for discharging him, then against somebody for instructing his employer wrongfully, and then against the governor of this hospital for giving the order for his reception, and against me for receiving him and detaining him, and finally for discharging him prematurely. And so action after action was brought, and as soon as he failed in all these, whenever there was a litigious lady before the Courts he was always willing to support her, writing to her and saying he would be very glad if he could only get at Dr. Savage. Here was a type of disorder following alcoholism, and it should be a warning to you to be careful in certifying such people, because although they are of unsound mind, they themselves strongly object to being looked upon as insane, and they so nearly recover that they cannot be detained longer at present, under the law, and they are discharged with the results that one has already spoken of.

To continue, then, this patient, you hear, says he saw, and still sees, visions and hears whispers. He says he has a weight at his heart, and is no longer able to resist the whispers. You will have noticed that it is difficult for these patients to explain thoroughly what they feel. It is all very well for us to talk about hallucinations, but those of us who have had no hallucinations cannot understand them. Remember that peripheral neuritis is a common symptom of alcoholism, and misinterpretations of peripheral neuritis are common. It is one of the commonest things possible for people who have suffered in this way, even though the symptoms of peripheral neuritis may not be very well marked, to tell you that they are subject to electric shocks and sparks, and they will say just what the subjects of locomotor ataxy say, that their legs are made the means of communicating electricity or are made into lightning conductors. What I have pointed out to you several times already has been this: That the insanity in nine cases out of ten is in the interpretation of the feeling. For a man to say that his head feels as heavy as lead it not an unreasonable thing; but if a man positively asserts that his head *is* lead, then he is deluded. I saw an alcoholic in a private asylum yesterday, who had got with the peripheral neuritis a misinterpretation of his abnormal feelings. He said they had some means of introducing wires into his muscles. I said, "Very well, where are the wires?" He replied, "You do not suppose they are going to expose their tricks, there is such a thing as wireless telegraphy, why should not there be wireless telegraphy in this?" He said, further, "I do not see why they should put me in connection with the comic operas; when I want to go to sleep I hear the tunes which are being played by the orchestra. It is all very well for the Queen; she may have the wires laid on at Windsor when she likes, but I do not see why I should have them when I do not like." Here, again, are hallucinations in which alcoholism has played a very important part. He said, "I do not know why, when I close my eyes at night, I should have all sorts of spirits, goblins, and phantasmagoria playing before me." All these may be looked upon as being interpretations of peripheral neuritis occurring in central and common sensory nerves. Another person suffering from alcoholic insanity tells you that he has been poisoned. Sometimes I say, "Yes, only you misinterpret the poisoning, it is the alcohol which has been poisoning you." They say, "Oh, no, it is something more than that." One notices that the tongue is dirty and furred. The patient cannot take his food properly, and he has mucous vomiting, which he says is because he is poisoned. The fact that he has sickness and a bad taste depends on the alcohol; the insanity consists in the interpretation. This man tells us he was so sleepless that he took a good deal of alcohol to induce sleep. One has to remember

that taking alcohol in excess may be a cause of insanity, or it may be a symptom of insanity. There are a number of people sent to asylums as suffering from alcoholic insanity, whereas they are suffering from a nervous disorder for which they have taken alcohol; they take to drink in the way so many, I regret to say chiefly medical men, take to morphia. Such say they had sleeplessness and neuralgia, having had five or six bad nights and anxious cases, and they have begun by taking a very small subcutaneous injection of morphia. I regret to say many doctors think it is rather nice to know what is the experience of taking morphia, and they end by becoming victims of the habit. Alcoholic insanity may be a reaction; the patient first of all being sleepless, wretched, miserable, and excess of alcohol is again taken to overcome these troubles, and this produces further disorder which generally leads to delusions, a delusional interpretation of the feelings of peripheral neuritis.

Melancholia is a very common result of alcoholic excess. Again you may compare the acute with the chronic states. The morrow of the debauch means headache and misery. A person who has been continuing drinking for a considerable time may have an attack of mania, which lasts for a few weeks, and then passes off, the patient becoming intensely depressed.

There are some people in whom restlessness and buoyancy lead to drink. Drinking is the earliest stage of their insanity, then they may become depressed. Take as an example a man who was in Bethlem Hospital many years ago, who was a reporter to a leading paper, and a clever fellow all round. He was admitted into the hospital with acute mania following a very acute debauch. He was very excited for a time, and then he became intensely depressed. He got perfectly well and left the hospital. Next time he broke down he was buoyant and took a lot of drink, but before he came into the hospital he had passed into the depressed state again. The next time he was extremely excited, and arrived at Bethlem one Christmas morning, and said—what was true—that he had come from Tunbridge Wells in a special train which he had secured; that he had ordered a dinner for me and a dozen others at the hotel, and that he was going to collect us all in the special train and take us down. He did *not* go back by the special train, but was persuaded to stop with me at Bethlem, and was certified. After that there came the period of depression, and when he went out he said, "Never more." His age was 40. He came of an insane stock, there having been three or four instances of madness in his family, nearly all following alcoholic excess. He said, "Next time I find I have gone over the border I shall kill myself." He did so; he blew his brains out during the next attack of depression following an acute alcoholic debauch.

There is no doubt that alcoholics are very often suicidal, much more impulsively than determinedly, as in the case I have already mentioned. I told you about the man I saw yesterday. I told you he had better not be certified. But his friends said, "What? Are we to see him kill himself or see him rush away, as he says he intends to do, to the North of England and say 'Good-bye' to everybody, and make a fresh start in this or the next world? Are we to submit to that?" I replied, "What would you do if a man got delirium in pneumonia or in any other fever?" "We should send for two or three nurses." That is just what you have got to do now. It may be said that he will resist, so he may in other illnesses to which I have referred. In neither pneumonia nor in fever would you treat the delirium as the manifestations of a lunatic. It is possible he may become a lunatic, but you are not going to send him to Bethlem as a lunatic if he is suffering only from pneumonia. So you have to remember that there are cases in an early stage of lunacy which have to be put under the control of two strong men, if you can secure them, rather than certify them.

The next patient we shall see is aged 53, of good education, and has been employed in an insurance office. This is the first attack, and it has lasted seven months. The supposed cause is nervous exhaustion, that is the predisposing cause; the exciting cause is excess of alcohol. He has sometimes been threatening and dangerous to others. He has certainly been intemperate. It is not known whether there is any insanity or nervous disease in his family. There is no consumption in the family, but the patient was always nervous and excited. He has been an athlete. It is said that he used to be a moderate drinker. But he developed ideas that he was being followed and persecuted. He suffered incessantly from hallucinations of hearing, so that he heard a pot-boy calling him abominable names and following him He also thought there was a conspiracy to do an injury to his son. He thinks he is superannuated from his office on full pay, which is not true. He also frequently hears voices calling out for help. He thinks that his son is royal, and that he himself is related to royalty. He speaks

through imaginary telephones, and he believes that his affairs and interests have been placed before the Queen. He told one doctor that there was a conspiracy to steal his son away. When asked to define the danger and whence he fears it, he declines to say.

Here, then, we have a man who has been nervous, who is of middle age, and I suppose we are justified in saying has been a steady rather than an excessive drinker, who developed delusions of persecutions and hallucinations, these have been chiefly of hearing since he has been at Bethlem. His memory is very weak. He cannot tell the date, and cannot find his own room at night. He retains his ideas of persecution, and does not seem to know where he is, nor has he any idea of time. He smokes during the greater part of the day, and does not otherwise occupy himself. Those are two or three important symptoms, and I think they are to some extent dependent on a change in the peripheral nervous sensations. You all know that our idea of space or distance is not an instinctive thing, it has grown up with our sensory impressions; space and distance are of significance to us through sight and through hearing and other sensory impressions. If with alcoholism you get perversion of sensation, also perversion of hearing and sight, it is not surprising that people who are alcoholics get extremely confused about time. Of course there may be another way of interpreting the matter, namely, that the alcoholic is given to prosing and babbling a good deal, and that his memory is failing. One has only to pass through the country and listen to the talk of the common yokel to realise this, and in the higher circles, too, where drinking has been free, one has to remember that there is a tendency to boast and babble associated with alcohol. Still, I do not think that covers it. If you were to ask an alcoholic dement who has never left his house for six or eight months, where he is and what he has been doing, he will tell you he has been down to the City that day and has just got back, and that he always goes to business daily. You may ask another how he is, and he will answer, "All right, I am going home soon," while he is at home all the time, and in the house he has been occupying for twenty years. Confusion of time and space, and mistakes of identity, are very common in alcoholics, and there is often an associated loss of memory, especially recent memory. One wealthy patient I had to see two or three times a year for seven years had no recent memory at all, although he remembered what he had spoken about and the books he had read and the presents he had made, the regiment he was in, the officers he had with him, and the engagements and other things he had been through; he could talk nicely and be as companionable as possible, but once cross the line of six or seven years ago and he knew nothing; bring him down to to-day and he knew nothing. A man had looked after him in the most kind and considerate way as his gentleman companion for over two years, and had an attack of peritonitis and died, and I said to the patient I am referring to "It is very sad about poor So-and-so." But he did not remember his existence, although he had lived with him every hour of the day for two years, and had never left him. When I went to see him I was ushered in as Dr. Savage, from London, to see him about his memory. He would mutter "Dr. Savage, from London, to see me about my memory"; and if I disappeared into the next room to get something and came back he would have forgotten all about it and would have to be told again who I was.

Now this patient before us says he went home one night and had something to drink which sent him into a deep sleep; he drank something which he found on the table. He had insensibility following it and went to bed, and when he awoke next morning the house was empty, and three or four persons came to him and after a desperate struggle brought him to Bethlem. That was on the 10th of January of the present year, and the present month is June. He tells us finally that "That is all I can say about it." Now, it would not be an easy matter to sign a certificate from the present investigation. He resents cross-examination, as these alcoholics often do. They will often say "I say so and so; if you do not believe it, well and good, there is nothing more to be said." There was a man I saw at a private asylum who said, "Well, I was told by the Lord Chancellor's visitor that a thousand people had been murdered in this asylum." I said, "Surely no Lord Chancellor's visitor could make such a statement." He said, "Then you call me a liar and I decline to talk any more upon it." I said, "But it is a very important thing to know whether the thousand people have been murdered here. Is not it possible that the whole thing may be a mistake?" He said "What do you mean?" I said, "Well, you may have delusions." He replied, "Well that is the doctor's way out of it; I tell you definitely I was informed that a thousand murders had been committed in this place." Now that is another type of the interpretation

of these hallucinations. A man with peripheral neuritis feels very unusual, and he thinks he is being drugged, or is going to be killed, or is being electrified; at the same time he hears shouts and screams, sees passing shadows and flashes of light, and he has hallucinations of all his senses, and he believes there is a huge massacre continually in progress. There was a Scotchman I used to see in a private asylum —a powerful fellow. He would come up to me and say, "Hush, do you not hear them?" I said "No." He said, "Oh! you are daft; I forgot. There are hundreds of the Scotch nobility being killed out there."

Remember, then, that our patient is one who has had grand ideas—he believed that the Queen was interested in him, that his son was of royal origin, that he was going to enjoy his money without earning it. So that the symptoms were very like those of general paralysis of the insane. And here it may be as well to say how you would differentiate between a man like this with such ideas from a general paralytic? First of all the general paralytic, as a rule, sleeps better than the alcoholic. Next, the general paralytic has generally some inequality of pupils, with slowness of reaction. Next, the alcoholic may have very marked tremor of the tongue and labial muscles in the early stages, but if he has been under care for two or three months the chances are that that tremor will have passed off, whereas with the general paralytic the tremor and the hesitancy of speech will have increased in all probability. In this particular case you will have noticed that the speech is as clear and as crisp as possible. Then there comes the question of the reflexes. You may get a peripheral neuritis with changes in the reflexes, but in general paralysis of the insane you generally get a very great alteration, either in the matter of increase or defect. Then, again, the exaltation of a general paralytic is more universal and more benevolent; our patient has monomania of persecution, with the idea that his son is a grand person. Those are the essential points which distinguish general paralysis from alcoholism.

The next patient who will be brought in is aged 43, a Cambridge man, married, with nine children. He was never in an asylum before, and it is not known whether he has had any previous similar attacks. Worry and anxiety are given as the predisposing causes. His mother is said to be very eccentric. His grandfather committed suicide, and his grandmother died of phthisis. His father was a great drinker. He was studious as a boy, but became wild when he was at the University. He had influenza badly two years ago, syphilis sixteen years ago, for which he was treated for a period of four years. He has been intemperate for two years, and has been gradually getting worse. For the last thirteen years he has been suffering from fits of depression, which lasted for several weeks, during which he was morose and silent and would drink more than usual. He talked wildly at times, and had hallucinations of conversations with persons at a distance. His conduct was very erratic and unnatural. He is now suffering from mania; he talks incessantly in an irrational manner, and appears to have no idea of time, or of his own age, for he tells us he is seven years old, and at the same time says he is a grandfather. He believes he hears the voices of invisible persons speaking to him and that an invisible body was struggling with him on the bed. He is not suicidal, but says he has been given poison by others. He had a tendency to wander from home. He has seen his own devil sit beside him, and he hears voices at a distance, but has no other hallucinations. He has complained of a fat woman trying to strangle him at night. His pupils are dilated, with slow reaction to light and to accommodation. Last week his knee-jerks were present on both sides. His sleep and his memory are bad. Here, then, is a man with insane relations, who has had a good deal of worry and anxiety, has had syphilis, and has drunk excessively. The question which should be settled in your mind is whether the patient's symptoms depend chiefly on drink, chiefly on syphilis, or chiefly on heredity. The chances are that we have here a man predisposed to nervous illness whose syphilis may have altered the nutrition of his brain through affecting his arteries, who, feeling himself going wrong, has tried to keep himself up with alcohol, and this has further tended to degeneration. The prognosis in a case of this kind would be less favourable, of course, than if there had been no syphilitic history. With the syphilitic history it almost certainly means that the man is degenerating in other ways. The essential point of diagnosis is whether the man is suffering from general paralysis or alcoholic insanity. It is well also to remember what I have told you, that although the symptoms produced by alcohol are extremely like the symptoms produced by general paralysis, at the same time general paralysis is not very commonly produced by alcohol pure and simple. It is very uncommon to get general paralysis of the insane produced purely by drink, and this means an enormous difference in the prognosis. A man

who has become demented on account of alcohol *plus* syphilis, has definite brain changes. This man hears voices, and they tell him to do things. They tell him not to take his food. He sees things in his room, sometimes faces. He sleeps very badly, and thinks he is visited by demons, the said demons damaging his backbone. He believes the devil to be at the bottom of all this annoyance. He does not know whether he has relations who would protect him if they could. He has lost mental power; he cannot read or write now, and he has been in the hospital since November last. Voices in these cases are of two kinds; in this case they are commanding and dangerous type. The other variety is the annoying type, which may say "You are a fool," or "an idiot," or the like. But when a patient hears voices which tell him not to eat his food, and he obeys those voices, it becomes a very grave and serious matter. This man is very conscientious. Sometimes I say that the only really conscientious people I see are in asylums, simply because they are so absolutely single-minded. The absolutely reasonable person who is governed by the fact that for every *pro* there is a *con*, and as a result does nothing, is the sort of person who drifts into an asylum. These people are said to be suffering from the folly of doubt. This man would die conscientiously, because he obeys the voices which tell him not to take his food. The British juryman says: "Oh, yes, a man understands this, that, and the other; he understands the consequences that follow from this, that, and the other; *therefore* he is perfectly reasonable and responsible for all his acts." But this does not follow at all. We are each of us obliged to act to a certain extent on the belief that all sane persons reason along similar lines, but the insane do not always reason thus. But when I spoke of the truly conscientious person being seen in an asylum I meant that there are men like our patient who hear voices telling them not to take their food, and they act up to their belief. You or I, hearing even a physical voice saying, "You are not to take your food," would not obey. *We* cannot place ourselves in the attitude of that man who is refusing his food due to voices from an unknown source, and yet in many other respects he is perfectly reasonable. Therefore, in considering insane people you cannot judge every insane act as the natural outcome of either sane or insane data. The man is physically ill and requires nourishment badly, and therefore he requires enforced feeding. Whether he will get well and return to the drink is another question which we cannot solve.

The next case you will see is a man aged 56, of good education, married, a builder, and the supposed cause of his insanity is alcoholic excess. I have told you that alcoholic excess may be a predisposing or an exciting cause, or it may act in both ways. A man may soak, and soak, till he produces temporary or partial weak-mindedness and then drink himself into acute mania. Our patient's mother is melancholic. One aunt is said to have committed suicide; maternal aunt committed suicide, two sisters said to be nervous. There is also a very strong alcoholic history on both sides. The father recently died of bronchitis and cardiac failure. There is also ichthyosis in the family. The patient has been cheerful and lazy, but latterly has become more gloomy. He is fond of his children, but neglects them for drink. He has been intemperate since boyhood, and has drunk whisky chiefly; he was a steady drinker, and there have been no temperate intervals.

The term dipsomania covers several varieties of alcoholic neuroses. There are some individuals who have current attacks of insanity, each attack being associated with a desperate longing for drink. Those are true cases of dipsomania. There are others, in which there are recurring periods of depression, the only relief for which the patient finds is to drink himself into insensibility. The first cases may drink and enjoy themselves, while with the second the one object is to drink themselves out of misery. There is still a third variety of dipsomaniac. These people have recurring attacks of excitement, during which there are recurring periods of defective self-control, this defective control showing itself by drinking anything which comes in their way—acute recurrent mania if you like, with a tendency to alcoholic excess; but while ordinary attacks of recurrent mania generally last weeks or months, recurrent attacks of drunkenness may last only a few days or a week. Here is a man who had not been a dipsomaniac but a chronic steady drinker. There is in him a general condition of apathy, an inability to enter into conversation; frequently he attempts to pick up invisible objects, he is constantly talking to himself, and makes sudden remarks, as if in answer to a question when nothing has been said to him. His sister says that he has had for some time hallucinations of sight and hearing. He has recently become dirty in his habits, incapable of dressing himself properly, and may put on his coat as if it were a pair of trousers. He took no notice of what was going

on around him, and did not recognise that he was in his own house. He answers incoherently, and sees dogs which do not exist. He had delirium tremens in 1891, the first attack having lasted six months. He saw devils in his room, and heard voices, which he answered. He also tried to jump out of the window. He has been in here five months, and says he is very ill. He does not sleep very well, but has "rheumatics and sciatica." I think one may probably attribute these to peripheral neuritis. He says the sciatica is on both sides, and if you get a double sciatica of that kind it is well to look for some central or general peripheral cause. His appetite is good. He does not remember coming into this institution at all. His memory is improving, and he knows the day of the week and the month. His reflexes are all right, and he is convalescing. Now that man is practically convalescent, and he is just in the condition when it would be worth while for the medical officer to find out whether he is grateful or not. It is a very valuable axiom that no person suffering from mental disorder is well till he recognises that he has been ill and is also grateful for the treatment. One of the proofs that nearly all alcoholics are only relieved and not cured is that they are scarcely ever cognisant of their illness, or grateful for what has been done for them.

There are just a few things that one would sum up in relation to these cases. First of all, you may have acute alcoholic bouts producing acute insanity. The weaker the patient is, nervously, the more likely is he to be upset; so that if a patient has had an injury to his head, the results will follow more quickly and with less cause. Persons also who have had a recent serious illness, and those who have had influenza badly, are often readily affected by alcohol. With a fair number of people when they get on in years their tongue is too readily loosened by a little alcohol. One more point: the general paralytic is very readily affected by alcohol, so that I have known a man who had lived freely and had been able to take any amount of alcoholic stimulants, nevertheless begin to show the symptoms of the general paralytic after taking a glass of wine. He was induced to get up and return thanks for the health of the Queen, and the single glass had made this man, who yet had been a hard drinker, drunk. That instability is one of the symptoms of the general paralytic. I have always told you that in a man having become degenerate from excess of alcohol, a comparatively small amount may start acute mania, which may be true delirious mania of the worst type, or you may have ordinary emotional mania. I have told you, you may get melancholia, either coming on directly after drink, or, and more commonly, coming on as a secondary symptom following the maniacal stage. During a condition of that kind suicide is common and has to be guarded against. Delusional insanity is very commonly the result of alcohol; a large proportion of the persons who believe they are persecuted, annoyed, tortured, and interfered with are alcoholics. One has got to look at two explanations. One man suffers all sorts of uneasy feelings, and says he is persecuted. Another individual suffering similar feelings interprets them by saying that he is ill; as an example, he may say that he has got internal cancer. So that the same real disorder, the same change in the peripheral nerves, may be interpreted by one man as persecution and by another as a hypochondriacal set of complaints. A man who has been alcoholic may lose sexual power or sexual desire, or both, and as a result he may become a desperately dangerous man. Jealousy follows upon this defect. Quite recently I saw a man with a strikingly handsome wife. He had lived an alcoholic life, and had become practically impotent for eighteen months. He was and is intensely jealous, and it is a question whether he will not have to be separated from his wife to prevent danger. A patient we had in Bethlem used to be intensely jealous of his wife, who came on visiting days, and he would count by the clock the moments that it took his wife to leave him and to appear at the front gate, because he believed some of the medical officers might be intriguing with her. Remember jealousy is a common and dangerous symptom associated with alcoholism. The ordinary type of progressive alcoholic mental disorder is towards weak-mindedness, and it is of the type I have mentioned, a defective knowledge of time and space, so that they do not know where they are, they do not know how long they have been there, they make mistakes about their relations, and it is in connection with these cases that there are so many disputes about wills, because they forget so much, and they are so easily influenced by boon companions. When comparing general paralysis and alcoholic insanity, I have told you that many of the symptoms are common to the two. In the alcoholic there may be epileptic fits of a very marked kind; in fact, it is hardly possible to distinguish between the fits dependent upon alcohol and the fits dependent on, or occurring in, the early stages of general paralysis of the insane. Remember, then, that alcohol may

produce temporary disorder of almost any kind. It may produce decay to any degree. You are also to bear in mind, however, that there are very few of the symptoms which may not be curable. If, however, you get advanced peripheral neuritis, with marked muscular wasting, it is very likely that these muscles may never recover; and, in the same way, if you get absolute loss of recent memory, and that loss of recent memory lasts for six months, you may practically say that that patient will never recover his memory.

There is one interesting point that I had almost omitted in reference to the loss of memory. With that loss of memory there is loss of desire for alcohol in nearly every case. Take this patient in the North, to whom I have already referred. When I visited him I went after dinner into the billiard room and played billiards. Whisky and brandy and soda water were on a side table. The patient would go up and take a bottle of soda water, and would not touch the stronger drink; he had no desire for it. If he had begun to recover his memory, however, he would have begun to regain his desire for drink. I was asked some time ago to go and see a lady, the wife of a leading solicitor, who had drunk herself into temporary weak-mindedness and complete loss of recent memory. The husband said to me, "Do you think my wife will ever recover?" I said, "She will probably recover her memory, but I advise you not to pray for it, because if she gets back her memory she will also get back her desire to drink." He said, "Oh, no; when she was comparatively well I dared leave a decanter of spirits about and she would never touch it." I said, "If she gets well she will take to drink again." The next I heard of the case was that the lady had recovered her memory and also her desire to drink. So loss of memory in alcoholics may be a blessing in disguise.

Nursing Notes.

We suppose that heat engenders inactivity amongst the nurses as well as among other less favoured people. Certainly nothing worthy of notice in this column has happened during the past three weeks. Every one who can be spared is away on a holiday, and if probationers are rejoicing in a little slackness from the absence of head nurses, sisters pay the penalty from those same probationers' ignorance.

Soon we shall be surfeited with committees. Now, we should hail one with delight, an oasis of news in a desert of dearth. There will be much to be done in the late autumn in the way of amalgamating and arranging our various clubs and societies, and we hope to see some further effort towards the founding of a good library.

One of the greatest of the many privileges the nurses have been granted within the last two years has been that of having the pick of the park reserved for their exclusive benefit. It has been much appreciated by all and abused by some. When we say abused, we refer to the manner in which bits of newspaper and pieces of rag have been left lying about on the grass by the untidy ones, giving the lawn somewhat the appearance of a party of cheap trippers having pic-nicked there; it only needs a few ginger-beer bottles to complete the resemblance.

A nurse may not run—firstly, it is unprofessional; secondly, it is undignified; finally, it is unsafe, especially in subterranean passages. The workmen lay fresh traps in fresh places every day. If the paving-stones are up at the corner one day, they are down the next with a heap of gravel on top; boards that are crossways one morning are lengthways or absent the next. Therefore, hurrying to breakfast in the gloom is not safe, and it rather behoves one to walk circumspectly. We make no mention of the path from the Colonnade to the subway; for this a special instinct and electric light are necessary.

One of our nurses travelling the other day encountered a person in a kind of fit. She was much embarrassed. The crowd which collected round expected her to do great things, probably instantly to restore the person to a state of health, and showed much disappointment that she only recommended the fitter to be taken to the nearest hospital. Privately afterwards the nurse confessed herself floored; she said she could have been quite happy and more at home if they had presented her with an abdominal section in a difficulty. If the "First Aid Lectures" help one to cope with these little occurrences perhaps they are not to be sneezed at.

In Mary (the worst of being a patient of Mr. Fripp's).—Grannie (a colotomy of two days) to Nurse: "My dear, I should feel quite well and very comfortable if I hadn't got all these Prince of Wales's on me." And the intelligent probationer adjusted the Spencer-Wells' forceps.

"L'INCONNUE."

Passim.

By the retirement of Dr. Pye-Smith this month, Guy's Hospital is bereft of a great personality. A man of world-wide fame, a thorough scholar, and a great physician, his loss will be deeply felt by all at Guy's, both by his colleagues on the staff, and by the men who have had the good fortune to benefit by his teaching. The large crowd which accompanied him on his last round in the wards last Thursday week, was an attempt on the part of all up here to convey to Dr. Pye-Smith their admiration for him and his work, and to give him a worthy farewell.

As a teacher, Dr. Pye-Smith was pre-eminent. His enthusiasm for his work was immense, and infected the most apathetic, and his patience in ceaselessly teaching the ground-work of medicine was boundless. But the most valuable part of his teaching was his treatment. In these days, when the trend of medicine is rather towards an unsympathetic science than a healing art, Dr. Pye-Smith never lost sight of the fact that to the majority of the profession, the general practitioners, successful treatment was the root of all success, and his teaching was always to that end.

For all public functions, we have lost an orator; at public ceremonies, prize-givings, and the like, it was always a relief to see Dr. Pye-Smith rise and with absolute fluency and unerring good taste say the right thing at the right moment in language which all could but envy. We can only hope that it will be our privilege to hear Dr. Pye-Smith as often as possible at Guy's again on such occasions in the future.

Now that Dr. Pye-Smith has left, the physicians have again changed round in the medical wards. Dr. Perry becomes full physician and Dr. Fawcett assistant physician corresponding to him.

Dr. Taylor and Dr. Hale White have their beds in Philip, and Dr. Pitt and Dr. Perry in Stephen; this new arrangement necessitates a fortnight's continuous take-in for each of these wards instead of every alternate week as heretofore. The advantages or disadvantages of this arrangement remain to be seen.

The changes on the medical side have been so great in the last few months that it may be worth while, at the risk of saying what is already known, to state the order of the take-ins.

Mr. Howse and Dr. Taylor now correspond and take-in the same week; the other corresponding Physicians and Surgeons are Mr. Davies-Colley and Dr. Hale White, Mr. Lucas and Dr. Pitt, Mr. Golding-Bird and Dr. Perry.

Dr. Perry, having become full Physician, will give up post-mortems, but we are glad to be able to announce that he will still take Skin Out-Patients every Tuesday as heretofore

An important notice has been posted in the Colonnade this week with reference to appointment of dressers and extension dressers. It is to the effect that applications for these posts, among others, commencing November 1st, will *not be considered till October 15th*, and applications may be sent in as late as that date. We imagine that this, taken in conjunction with the new scheme of extensions for dressers, means that in the future extension dresserships will depend in some degree upon each particular man's performance of his duties in his first three months, and not on his previous record alone, as was the case formerly.

We must heartily congratulate Nurses Nutt, Clarke and Powell upon their decoration with the Royal Red Cross of the Victorian Order. They certainly deserve some honour and recompense for the exceedingly good work they did on the Niger for twelve months, and readers of the Gazette may remember that a good deal of the credit of the successful treatment of blackwater fever was given to them by Dr. Wordsworth Poole. Nurse Nutt has already returned to West Africa, but Nurses Clarke and Powell remain in England, at any rate for the present.

While speaking of the Niger it may be worth mentioning that there are one or two vacancies for Medical Officers in Nigeria, and particulars can be obtained from Mr. Fripp, to whom applications should be made.

The work of building the new Nursing Home and the new Laundry is proceeding apace. Two temporary engines have been installed in the laundry yard to run the machinery for the present, and the old laundry chimney has been taken down. The warehouses in King's Head

Yard have disappeared, and most of the new foundations are laid down. The large block of buildings which will shortly rise in this situation will come up level with the further end of Clinical building, and will extend backwards nearly into the Borough. Lydia is being refloored and done, and the new sanitary wing to the Surgical block is in active progress. With all this going on, there are nearly as many workmen as students about the hospital now, and they are quite as busy.

WE have had occasion before now to point out the valuable field for original observation there is in the out-patient department of the hospital, and what a valuable medium for publication there exists in the columns of the GAZETTE, an advantage hardly sufficiently appreciated. The importance of the work that might be done by A.H.S.'s and A.H.P.'s was the subject of a few remarks made by a member of the staff the other day. He said that of minor surgery, many of the surgeons saw very little; of the treatment of slighter fractures and dislocations they saw nothing. He quoted a valuable paper by a former assistant house-surgeon, who collected and tabulated the work of three months in the front surgery, the various fractures seen, their treatment, and the results of that treatment. This made an interesting record, was original work, and was of great value to those who do not have such opportunities. Similar fields for work exist in all the out-patient departments. We would recommend an effort in this direction to some of those residents about to be appointed; it is a pity that such a mass of useful experience is passed by unnoticed.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

CASES UNDER DR. TAYLOR.

MARY	38.	Mitral regurgitation. Fibroid lung.
	39.	Carcinoma hepatis. Primary in rectum.
	41.	Rheumatism. 3rd attack. Endocarditis.
	42.	General anasarca. Chronic tubal nephritis.
	43.	Abdominal pain. ? Perimetritis.
	45.	Chorea. First attack.
	46.	Lead poisoning.
MARY	47.	Hysteria.
	48.	Gastric ulcer. ? Tuberculous ovary.
	49.	Ascites. Old lung disease. Failing right heart.
	50.	Jaundice. Ascites. Proliferating papilloma of ovary.
PHILIP	21.	Eczema.
	22.	Left basal pneumonia.
	24.	Dropsy. Tubal nephritis.
	25.	Bronchitis. Recurrent emphysema. Adenoids.
	27.	Tabes abdominalis.
	28.	Phthisis. Right and left apex with bronchitis.
	29.	Pleurisy with effusion right side.
	30.	Right hemiplegia. ? Syphilitic.
	31.	Caries of ribs. Operation.
	32.	Left apical pneumonia. ? Typhoid.
	33.	Tumour in loin. Operation. Fæcal fistula.
	34.	Nephralgia.
	36.	Phthisis.
	37.	Ascites, secondary to abdominal carcinoma.
	38.	Acute rheumatism. First attack.
	40.	Left pleuritic effusion. Dry pleurisy on right side. ? Tuberculous.

CASES UNDER DR. HALE WHITE.

PHILIP	1.	Chronic Bright.
	2.	? Aortic aneurysm. Mitral stenosis and regurgitation.
	3.	Acute nephritis.
	4.	Infective endocarditis.
	5.	Enterica.
	6.	Pyrexia. Innominate fever.
	7.	Influenza.
	8.	Hæmatemesis. Cirrhotic.
	9.	Mitral regurgitation.
	10.	Jacksonian epilepsy.
	11.	Duodenal ulcer.
	12.	Dilated stomach.
	14.	? Enterica.
	15.	Infective endocarditis.
	16.	Acute nephritis.
	17.	Colic. Acute dermatitis.
	19.	Enterica.
	20.	Phthisis. Hæmoptysis.
MARY	14.	Enterica.
	15.	Cirrhosis. Ascites.
	16.	Empyema.
	17.	Jaundice. Gall-stones.
	19.	Adiposis dolorosa.
	20.	Raynaud's disease. Early gangrene.
	21.	Enterica.
	22.	Bright. Chronic.
	23.	Jaundice. Malignant.
	24.	Acute rheumatism.
Cot	53.	Diarrhœa and vomiting. Marasmus.

CASES UNDER DR. PITT.

MARY
25. Chorea.
26. Enterica.
27. Congenital hemiplegia.
28. Enterica.
29. Rheumatism and pericarditis.
30. Cirrhosis.
33. Sigmoidectomy.
34. Gastric ulcer.
35. Hysteria.
36. Chronic tubal nephritis.

STEPHEN
22. Fibroid lung and bronchiectasis.
23. Gastric ulcer and dilatation.
24. Empyema.
26. Acute rheumatism.
27. Mitral and tricuspid stenosis.
28. Mitral stenosis.
30. Pericarditis.
31. Acute pulmonary tuberculosis.
33. Convalescent pneumonia.
34. Acute rheumatism.
35. Pleurisy.
36. Syphilitic cerebral endarteritis.
38. Renal calculus.
40. Empyema.

CASES UNDER DR. PERRY.

MARY
1. Acute rheumatism. First attack.
2. Bronchitis and emphysema.
3. Bronchitis. Pleurisy. Enlarged liver.
5. Optic neuritis. ? Cerebral tumour.
6. Chronic diarrhœa.
7. Chorea.
8. Diarrhœa with melæna.
9. Enteric fever. Second week.
10. Acute rheumatism.
11. Epistaxis.
12. Chronic gastric catarrh.

Cot 51. Left empyema.
Cot 55. Diphtheria. Tracheotomy.

STEPHEN
2. ? Chronic empyema. Right.
3. Spasmodic asthma.
4. Acute poly-osteo-arthritis.
5. Pyloric stenosis. ? Healed ulcer.
7. Pleuritic effusion. Left. ? Typhoid.
8. ? Appendicitis. ? Neurosis.
9. Pneumo-hydro-thorax.
10. Syphilitic ulceration of face.
12. Acute rheumatism. First attack.
13. Enteric fever. Convalescence.
14. Aortic stenosis and incompetence.
15. Enteric fever. Convalescence.
16. Pyrexia. Headache.
17. Diabetes mellitus.
18. Retro-peritoneal abscess. Operation.
19. Enteric fever. Second week.
20. Acute on chronic Bright's disease.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

NAAMAN
1. Varicose veins.
2. Tubercular osteitis of head of tibia.
4. Tubercular glands in neck.
5. Irreducible hernia. Hydrocele of sac.
9. Psoas abscess.
11. Hæmorrhoids.
12. Tubercular epididymitis.
13. Fistula in ano.
14. Tubercular knee. Excised.
15. Tubercular hip.
16. Recurrent epithelioma of eye.

DORCAS
2. Cut throat.
4. Strangulated femoral hernia.
5. Irreducible umbilical hernia.
6. Abdominal contusion. Laparotomy.
7. Adenoma mammæ.
8. Tubercular ankle. Syme's amputation.
9. Branchial sinus.
10. Tubercular glands in neck.
11. Strangulated femoral hernia. Fractured tibia.
12. ? Old impacted fracture of neck of femur.
13. Impacted fracture of neck of femur.
14. Carcinoma mammæ.
15. Hæmorrhage into spinal meninges.
16. Suppurating glands in groin.
17. Melanotic sarcoma of cheek.
18. Varicose veins. Thrombosis.

Cot A. Irreducible inguinal hernia.

ASTLEY COOPER
1. Ruptured urethra. Perineal section.
2 & 3. Compound fracture tibiæ and fibulæ. Wired.
4. Crushed foot.
6. Fractured jaw.
7. Hæmatoma of leg and arm.
9. Fractured patella. Wired.
12. Compound fracture tibia and fibula.
15. Fractured humerus.
17. Contusion of back.
20. Fractured femur.
22. Concussion.
26. Ruptured urethra.
27. Fracture of neck of femur.
32. Concussion.

CASES UNDER MR. DAVIES-COLLEY.

JOB
1. Hydrocele of cord.
4 & 5. Tubercular knee.
7. Periostitis of femur.
8. Carcinoma of rectum.
10. Necrosis of scapula.
11. Hydrocele.
12. Actinomycosis of appendix.
20. Tubercular testis. Castration.
22. ? Renal calculus.

JOB 23. Epithelioma linguæ.
24. Inguinal hernia.
LYDIA 2. Excision of kidney.
3. Chronic mastitis. Cystic.
5. Bullet in brain. Explored.
6. Strangulated umbilical hernia.
8. Epulis.
9. Synovitis of knee.
10. Appendicular abscess.
11. Needle in hand.
12. Nævus in neck.
15. Compound fracture tibia and fibula.
16. Needle in knee.
17. Tubercular glands in neck.
19. Prepatellar bursa.
Cot A. Irreducible inguinal hernia.
CORNELIUS 2. Crushed foot.
3. Fractured tibia.
4. Punctured wound of knee.
5. Cut tendons in palm.
13. Fractured fibula.
15. Compound fracture tibia and fibula.
17. Contusion of thigh. Fracture ninth dorsal spinous process.
18. Fractured femur and ribs.

CASES UNDER MR. LUCAS.

LAZARUS 1. Epithelioma of lip.
2. Necrosis of femur.
3. Tubercular glands in neck and axilla.
4. Appendicitis.
5. Tubercular glands in neck.
6. Right inguinal hernia.
7. Stricture.
8. Left inguinal hernia.
9. Fistula in ano.
10. Varicocele.
15. Inguinal hernia.
22. ? Renal calculus.
MARTHA 1. Pyonephrosis.
6. Mastoid abscess.
8. Carcinoma mammæ.
18. Tubercular mastitis.
19. Bullet in brain. Extracted.
21. Umbilical hernia.
22. ? Charcot's disease of ankle.
Cot B. Strangulated inguinal hernia.
D. Epulis.
ASTLEY COOPER 5. Compound fracture tibia and fibula.
24. Fractured femur.
25. Fractured spine.
31. Synovitis of knee.

CASES UNDER MR. GOLDING-BIRD.

LUKE 5. Irreducible inguinal hernia.
7. Mastoid abscess.
8. Sarcoma of tongue.
9. Varicocele.
11. Ulcerative colitis. Colotomy.
12. Enlarged prostate. Suprapubic puncture.
13. Stricture.
14. Ankylosis of elbow. Old fracture.
15. Hæmatocele.
18. Interphalangeal dislocation.
19. Strangulated inguinal hernia. Resection of gut.
20. Epithelioma of tongue.
21. Spinal caries. Psoas abscess.
CHARITY 2. Ventral hernia.
3. Strangulated femoral hernia.
4. ? Carcinoma mammæ.
5. Moveable kidney. Nephrorrhaphy.
6. Adenoma mammæ.
8. Tubercular knee.
9. Carcinoma mammæ.
10. Enlarged axillary glands.
11. Stricture of rectum.
12. Fractured tibia and fibula.
13. Tubercular knee.
14. Movble kidney.
15. Prepatellar bursa.
16. Hæmorrhoids.
17. Exostosis lower end of femur.
18. Femoral hernia.
19. Tubercular hip.
ASTLEY COOPER 11. Compound fracture tibia and fibula.
13 & 19. Fractured femur.
CORNELIUS 1. Injury to foot.
9. Compound fracture tibia and fibula.

CASES UNDER MR. JACOBSON.

NAAMAN 19. Dislocation of sterno-clavicular joint. Resected.
20. Inguinal hernia.
21. Varicose veins.
DORCAS 21. Recurrent appendicitis.
22. Irreducible femoral hernia.
PATIENCE 4. Necrosis of amputation stump.
5. Varicose veins.
SAMARITAN 8. Ischio-rectal abscess.

CASES UNDER MR. SYMONDS.

JOB 13. Stricture of small intestine. Tubercular. Resection. Circular enterorrhaphy.
14. Stricture urethra. Traumatic.
15. Mastoid abscess.
16. Sarcoma of tonsil. Abdominal metastasis.
17. Granulating wound of heel.
19. Dental cyst.
SAMARITAN 10. Necrosis of jaw.
PATIENCE 3. Horse-bite. Cellulitis.

CASES UNDER MR. LANE.

LAZARUS 11. Fæcal fistula.
12. Otitis media. Mastoid abscess. Brain explored.

LAZARUS	13.	Cystic kidney.
	14.	Psoas abscess.
MARTHA	12.	Movable kidney. Psoas abscess.
	Cot C.	Talipes equino-varus.
PATIENCE	1.	Erysipelas.
SAMARITAN	7.	Cellulitis of arm.
	12.	Gangrene of toes.

CASES UNDER MR. DUNN.

LUKE	1.	Inguinal hernia.
	2.	Necrosis of tibia.
	3.	Contraction of extensor tendons.
CHARITY	20.	Carcinoma of rectum. Colotomy.
	21.	Varicose veins.
	22.	Ventral hernia.
	23.	Epithelioma vulvæ.
	Cot D.	Inguinal hernia.
PATIENCE	14.	Cellulitis of neck.
SAMARITAN	9.	Tubercular hip.
	11.	Abscess in groin.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Locum Tenens.

SIR,—F.R.C.S. seems, from his confident tone, to think that he has settled the whole question, but although I never had the pleasure of his services (and indeed in my very unsurgical practice I should have shrunk from engaging him) I am content to accept his somewhat pharisaic view of himself that he was not as others. I will believe that his luggage did amount to more than one collar and a nightshirt, that he had a tooth-brush, that although his employer put a barrel of beer and a bottle of whisky at his disposal he did not get drunk in neighbouring public houses, that he occasionally rose at the ordinary hours of the house, and finally that he knew the rudiments of behaviour to a lady at table and elsewhere. There is no doubt that the professional locum knows none of these things, and does none of them. Probably that is why he is a professional locum. So I got an unqualified but well-trained Guy's man to come in and help my aged father, who is retired, while I went out with the wife, and was promptly hauled up by one or two neighbours for "covering." Then I got another Guy's man whose qualifications were great and whose manners were perfect. He took advantage of my absence with the wife to absent himself for twenty-eight hours, and I was telegraphed for to return from one hundred miles away. My last Guy's man was too satisfactory. He is a gem, and other people know it, and when he reads this he will realise that four weeks at £5 a week has so far entered into competition with my poor means that I am going to the Sanitary Congress without a locum, relying on the good offices of two of my professional brethren backed up by my aged "parient" and a first-class dispenser.

Let it not be forgotten that in addition to the three guineas, we have to pay a railway fare from miles away, and an agent's fee; even so I would pay four guineas willingly if I could go out for a week and leave behind me a qualified practitioner who was anywhere approaching a gentleman, and who had grasped the elementary idea that the object of his visit to my house was to do my business and not to exploit the neighbourhood for every other purpose.

I ask you not to disclose my identity, but beg to sign myself,— TERENCE.

Nursing News.

MATRON'S OFFICE.

We are afraid, owing to the holiday season not being yet over, that Nursing News will be just a little dull.

The Steam Navigation Company most kindly sent forty tickets for Ramsgate and six for Ostend for the use of the Nursing Staff. Several of the Sisters and many of the Nurses have availed themselves of these trips and enjoyed them very much.

On the 1st of September, three Guy's Nurses, viz., Nurses Nutt, Clark and Powell, were decorated by the Queen with the Royal Red Cross, in recognition of the devotion they have manifested to the sick in the Field Hospital of the West African Frontier Force, and their courage in contending with the many difficulties which are the necessary accompaniment of European life on the Niger. They seem to have enjoyed their day at Osborne exceedingly, and the Queen entered into conversation with each one separately, taking a keen interest in her personally, and in her future.

Nurse Nutt has already returned to Africa; the other two are still in England.

Some of the Sisters have returned from their holidays, amongst them Sister Christine, who in consequence of ill-health, has resigned, and leaves us in November. Out-Patients will miss her very much, and the hospital will be very sorry to lose her.

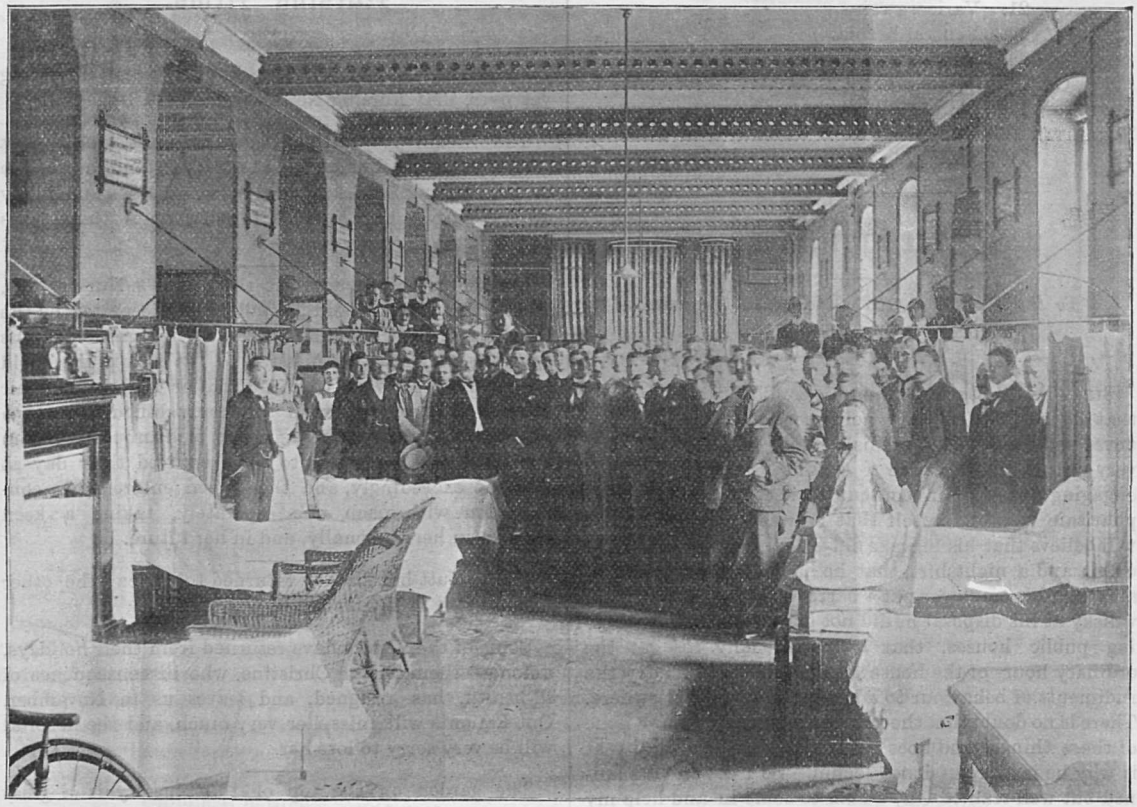
The garden on the top of the Nursery is a great success, and the Matron's Office is kept supplied with mignonette and nasturtiums grown in tubs up there. The access thereto is a slight drawback; a sort of Swiss châlet outer staircase would be more convenient, labelled "Nursing Staff Only."

The Bible Classes on Sunday afternoons are again to be taken regularly by the Chaplains. They commence at 4.15 p.m. in Sister Esther's sitting-room every Sunday, and tea is provided at 5 p.m. for those who attend the Class and any others who care to drop in between 5 and 6 o'clock.

Do we like the electric light in chapel (when it does not go out), or do we not? Someone says, "Yes, when out."

Dr. Pye-Smith's Last Visit.

ON Thursday, August 31st, Dr. Pye-Smith went round his wards for the last time. A vast crowd of his old ward clerks attended this final and most memorable clinique of our popular senior physician, and among the number were several old Guy's men who had come up specially for the occasion, and Dr. Hale White, Dr. Shaw and Mr. Fagge jostled with the rest. Dr. Pye-Smith visited each of his patients in turn, and it was characteristic of him that he taught to the last, though only a small proportion of those present were able to benefit by his teaching on this occasion. On leaving the wards, the crowd followed him to the colonnade, and here he spoke a few words of farewell. "It is very kind of you," he said, "to greet me in this way," and it is very gratifying to me to see so vast a concourse. As I look round me I see many faces that are familiar, and which I hope I may never forget. Good-bye and God bless you all." Three cheers were then called for, and these were repeated many times till Dr. Pye-Smith had driven out of sight.



Next, Dr. Pye-Smith wrote to his house-physician as follows:—

"My dear Fitz-Hugh,—I was quite unprepared for such a concourse at our going round to-day, and at the end was afraid to begin shaking hands and taking individual leave, or when would it have been over? So I write now to say farewell, and to thank you for your most efficient, constant and trustworthy help. . . . I hope I may see all of you again before you, too, quit the dear old place, and I shall always be very pleased to be of service to you, especially in the future.

One cannot break old ties that have lasted nearly forty years without feeling the wrench, and I wished to make the parting seem a short one in the ward. But I felt very much the good feeling of that great crowd of men, and shall never forget it. . . . .—I am always and sincerely yours,

P. H. PYE-SMITH."

Reviews.

The Temples and Ritual of Asklepios at Epidaurus and Athens. By Dr. Caton, Physician to the Royal Infirmary, Liverpool.

Dr. Caton took last year a tour in Greece, and gave the results of his observations in two lectures delivered at the Royal Institution. His principal researches were made at Epidaurus in Argolis, for near there was the Hieron, or the chief seat of the worship of Asklepios. It was in this place, tradition says, that the god of Medicine was born. An engraving shows the temple in which was placed the image of the god made of gold and ivory like the figure of Athena in the Parthenon. The god was sitting on a throne, a large golden serpent rising up to his left hand. There are other buildings near, whose use is unknown, but some are evidently baths, and there is also a large theatre or coliseum.

Quite lately a large ruin has been excavated at the Hieron, which Dr. Caton believes must have been the hospital. A very similar but smaller building exists south of the Acropolis at Athens, and called the Asklepieion. There are also shrines to Asklepios and Hygeia in many other parts of Greece.

The Hiereus, or chief priest, was also the physician, and Dr. Caton thinks that the priestesses might have been attendants or nurses. In a drawing of the building there is a room which would hold a hundred and twenty patients, the couches being placed side by side. Probably other buildings might also have had wards. This being the great shrine of the god of Medicine, thousands were yearly drawn to it, and it was no doubt used as a health resort by others, as the numerous buildings prove as well as the size of the theatre. This beautiful spot was only six miles from the seaport of Epidaurus, and here visitors could enjoy exercise, baths, massage, and the purest air both night and day.

In the valley there existed sacred serpents; these were tame, and fed by the patients on cakes. They were trained to lick any ailing part with their forked tongue, and Dr. Caton gives in his picture of the hospital the figure of a sick man having a sore on his leg licked by the sacred serpent.

Several tablets have been found describing the cures which had been affected. It may be remembered that

DR. PYE-SMITH'S LAST HOUSE-PHYSICIAN AND WARD CLERKS.

the British Museum contains many votive offerings representing the parts of the body which had been affected, and which had been placed in the temples of Asklepios. Here, also, may be seen the splendid head of the god himself from the Island of Melos, and which Dean Stanley described as a perfect specimen of the ideal which the Greek alone has been able to create—the divine in Man.

It may be mentioned that buildings exist in Rome which are believed to be hospitals, and of which mention is made in the writings of Marcus Aurelius. If this be so, and as they existed also in Greece, there is no reason why we should be constantly told from the pulpit that hospitals are purely Christian institutions, and that the ancients took no care of the sick. Hippocrates travelled about to the different baths, terminating his career in the neighbourhood of the places where the late battles were fought with the Turks. He was at Thermopylæ, and there died, and was buried at Larissa. The father of medicine was probably born about the time when the shrine of Asklepios was erected at Epidaurus, thought to be B.C. 450, and at the period of the Peloponnesian war.

Grosvenor Street. S. W.

The Hygiene of the Mouth: A Guide to the Prevention and Control of Dental Diseases. By R. Denison Pedley, F.R.C.S. Edin., L.D.S. Eng., Dental Surgeon to the Evelina Hospital for Sick Children, Southwark, London. Published in London by J. P. Segg & Co., 289 & 291, Regent Street, W. In America by S. S. White Dental Manufacturing Company, Chestnut Street, Philadelphia, U.S.A.

The author says in the preface, "The first chapter, which has already appeared in my book on *The Diseases of Children's Teeth*, has been revised, and more facts have been added. The chapter on Oral Hygiene in Adults, with the illustrations which accompany it, is now published for the first time."

The first chapter is, therefore, not new to us. In it the author emphasizes the importance of the greatest cleanliness in the mouth at all ages of childhood, and he says, "Tooth brush drill is as needful as any gymnastic exercise for the preservation of health." The use of the tooth brush as a preventive of dental caries is exemplified in the statement made that of 458 girls from parochial schools of the metropolis who entered domestic service, five-sixths of them had never known of its use!

The dental condition of 3,800 boys and girls, whose ages range from three years to sixteen years, is given. The statistics are from the children of the poorer classes at schools at Southall, Hanwell, Sutton and Feltham, and the number of sound dentitions—that is, requiring neither fillings nor extractions—is given as 828, about 22 per cent.

The examination of 500 boys and girls in the wards of the Evelina Hospital for Sick Children, whose average age was six years and six months, showed 90 sound dentitions—18 per cent. The comparison of these statistics is, perhaps, not of much importance on account of the great difference in the number of children's mouths examined, and their ages.

The diseases of the teeth affecting the nervous system—epilepsy, chorea, headache—the diseases of the alimentary canal, and of the respiratory tract, are interesting alike to the medical and dental practitioner.

The first chapter ends with the following sentence:—"An examination of a very large number of nurses forces the conviction that the hygiene of the mouth requires more consideration in nursing institutions than it at present receives." This indictment in no way applies to Guy's Hospital, as any of the nursing staff can testify.

In the second chapter the advisability of early dental treatment in adults is indicated, and various sound prophylactic means are recommended.

Many illustrations, showing loss of opposing teeth, extensive dental caries and abscessed roots, are given; but the precise purpose of some of them is not apparent.

We welcome this book as an honest attempt to teach surgical cleanliness in the mouth, but upon reflection we think that it is not quite satisfactory in its present form. We venture to suggest that future editions may be published with advantage in two distinct parts—one for the public, with many technicalities omitted, and the other for the profession, purely scientific. As minor points for consideration are—the addition of a good index, the advisability of recommending a nostrum (Parmena, a tooth powder) without giving the prescription, and the omission of the names of hospital patients.

A Handbook of Midwifery. By W. R. Dakin, M.D., F.R.C.P., Obstetric Physician to St. George's Hospital.

In spite of the fact that so many books are published expressly for students and practitioners, it is seldom that one meets with one which is not either too much of a "cram book" to be valuable clinically, or too scientific a treatise to attract the examination candidate. Dr. Dakin has steered successfully between these two extremes, and though his book will be welcomed more by the budding G.P. than the candidate for L.S.A. honours, yet its matter is presented in a form easily assimilable by anyone who has done extern.

The book is divided into two parts, Physiology and Pathology. Under the first come all the conditions of pregnancy, labour, the various presentations, their mechanism and treatment, the puerperium, and lastly the infant.

The development of the ovum is shortly and clearly put in the first fourteen pages and profusely illustrated, a great advantage, as more development can be explained by a few good diagrams than by pages of writing. Dr. Dakin treats as normal all positions of the fœtus in which its long axis coincides with that of the uterus; so that transverse presentations come under the head of Pathology, and so do Obstetric Operations, though it is to be hoped that they are not always pathological

processes. Perhaps the best part of the book is the chapter on the development and abnormalities of the pelvis. Some of the illustrations, which are purely diagrammatic, show very clearly the different changes and how they are produced. Indeed the illustrations all through, most of which are original, are excellent.

The treatment of the commoner forms of difficult labour is put rather shortly, and although it is extremely difficult to lay down rules which are of universal application, it is of great importance that the man of small experience should have some such dogmatic advice, as Dr Herman gives, to guide him.

It is also curious that the height of the fundus uteri above the pubes after labour, though treated at some length, is not mentioned in connection with septic affections. In cases in which this measurement has been carefully taken its variations have proved a sure indication as to the progress of the patient, almost as important as the temperature chart.

On the whole, Dr. Dakin is to be heartily congratulated, and we can recommend his work to anyone who wants a book both for an examination and for reference to in after years.

Pyorrhœa Alveolaris. By John Fitzgerald, L.D.S.

The author expressly states in his preface that this work is not intended to be an exhaustive treatise on the disease; at the same time he has treated the subject very thoroughly; the sections devoted to the Pathology and Treatment are very interesting, and the latter especially shows a large experience of the subject. One would wish that to the section on the diagnosis of Pyorrhœa, the author had appended some illustrations, as his descriptions are rather difficult to realise; and the book would have been more valuable had he illustrated some of his statements by records of actual cases. For instance, the average observer is naturally somewhat sceptical as to the importance of Pyorrhœa Alveolaris in the causation of gastric ulcer, or as to its being the source of absorption of toxines, giving rise to such signs as "pigment spots on the arms, tachycardia, goitre, neuritis of the sixth left intercostal in women, and peptonuria!"

Mr. Fitzgerald, like other writers of monographs, is evidently an enthusiast; but one would wish, nevertheless, that there were more books in the dental literature which, like his, were *readable* as well as instructive.

From the Gazette's Special Pathologist.

O. J. C., MARITZBURG.—Owing to an error in transcription, this specimen was described in a recent issue of the GAZETTE as a round-celled sarcoma. In reality the growth was a soft spheroidal-celled carcinoma affecting the peritoneum, and it may have arisen in the ovaries.

J., CORRIS.—Tubercle bacilli are present in the sputum in fair numbers. PATHOLOGIST.

In Lighter Vein.

SCENE—A Coroner's Court.

The twelve good men and true having viewed and gloated over the corpse are duly sworn. The first witness is called.

THE CORONER'S OFFICER. Take the book in your right 'and. (*Witness takes it in the left.*) No, that's the left. (*Witness kisses the book.*) No, not yet. Take the book in the right 'and.

(Witness *endeavours to do so, and drops it. Picks it up in the left hand, and kisses it.* Coroner's Officer *seizes the book and rams it into* Witness's *right hand, and rapidly administers the oath before* Witness *has time to perform any more gymnastics.*)

CORONER'S OFFICER. The evidence you give to this Court shall be the trewth the 'ole trewth and nothink but the trewth so 'elp you God.

WITNESS. Swelp me!

CORONER'S OFFICER. Kiss the book.

(Witness *takes book into her left hand and is about to kiss it, when* Coroner's Officer *pounces on her and forces it back to the right. At length the oath is successfully administered.*)

CORONER (*to witness*). Do you identify deceased as your son?

WITNESS. Swelp me Gawd.

CORONER. You need only answer Yes and No to the questions. When did you last see deceased alive?

(Witness *hesitates, uncertain whether Yes or No would be the more appropriate answer.*)

CORONER. Come, now, my good woman. Just think.

WITNESS. I seen 'im last Saturday when 'e come 'ome for 'is dinner.

CORONER. And that was the last time you saw him alive?

WITNESS. No, I seen 'im Sunday, and 'e says to me mother 'e says I think I'll run round and see Alf 'e says. Orl right Tom I says cos we called him Tom see? Dont be long I says cos I 'ad five children to look after and 'im the eldest, and of course I never thought as *'e'd* be the one to be took.

CORONER. Then, was the next thing you heard that he was dead?

WITNESS. No, not at that time see? Cos I didn't know 'ow it was going to be else I shouldn't of let 'im go, but I only says to Mrs. Blowzer last Toosday I says I know one o' my boys 'll meet 'is death sooner or later I says you mark my words I says. Well she says you always was a good woman she says all the years I known yer, and—

CORONER. All right, thank you. Has anybody any questions to put to the witness?

A Seedy Solicitor *arises from the table with considerable bluster.*

S. S. Yes, sir. My name is Bell. I have a very pertinent question to put to the witness. (*to witness*) Your son I believe is supposed to have been

killed by a train. Was he sober at the time of the accident?

WITNESS. I'm sure no son of mine was never nothink but what 'e should 'ave been.

S. S. Answer the question please—was he sober?

WITNESS. Certainly 'e was.

S. S. Oh, indeed! You were not present at the accident, I believe. No. Then how do you know he was sober? Still, you're his mother, so I suppose we can't expect you to adhere to the truth. That will do. (*Sits down with an air of complete satisfaction.*)

The next Witness is the Station Master *at the railway where the accident occurred.*

WITNESS. I was on duty as usual at five o'clock on Monday morning, when I saw diseased jump down on to the crossing, apparently with the intention of crossing the line. Just at that minute the 5.5 come in on the up line, and diseased not getting away quick enough, the buffer caught him, and seemed to like corpse him as you might say instanter.

CORONER. Any questions.

S. S. Do you allow the porters at your station to cross the line whenever they want to get to the other side?

WITNESS. Yes, but I always warn them to look both ways to see if a train's coming.

S. S. Was the 5.5 coming both ways?

WITNESS. No, sir, the 5.5's an up train.

S. S. Oh, indeed. What pace was it going at?

WITNESS. Matter of 20 or 30 miles an hour.

S. S. Do you consider that a proper pace for a train to be going at when there is a man on the line?

WITNESS. Well, y' see, they wasn't to know he was there.

S. S. Pah! What's the guard for? When you saw the train, as you allege, running over deceased, did you raise a finger to stop it?

WITNESS. Well, sir, I don't quite see what good I could have done.

S. S. Indeed. How many years have you been a station master?

WITNESS. Matter of fifteen, sir.

S. S. And yet you tacitly admit that you don't quite see what good you could have done. Thank you, that will do, we don't want to hear any more from you after that.

The H.-S. *is next called. The oath is administered, and he carefully kisses his thumb. He describes the injuries and the cause of death.*

S. S. (*with a somewhat more deferential air than before*). Just one question, Doctor—I don't want to detain you. Have you any proof that death was caused by the train running over the deceased? I presume it is possible that he may have got on to the line and died before the train ever touched him?

H.-S. His injuries were consistent with his having been run over by a train.

S. S. Yes, quite so. But that's not the point. However, to take another aspect of the case, you said, I think, that deceased had a fractured skull, six broken ribs, and a broken arm and thigh.

H.-S. Yes.

S. S. And I suppose you will admit that every single one of those conditions is, under ordinary circumstances, recoverable.

H.-S. Certainly.

S. S. Then I presume that if deceased had lived long enough he might have recovered.

H.-S. That does sound just possible.

S. S. Quite so. Thank you.

THE FOREMAN. Just one question. I suppose you did all you could for him.

H.-S. Well, he'd been dead an hour before I saw him, but I've no doubt the mortuary porter attended to his every want.

THE FOREMAN. In your opinion, doctor, if the train had not run into him, would it have killed him?

H.-S. I am afraid that is a question for a railway expert.

Several other less important witnesses are called, all of whom estimate the pace of the train differently, to the great satisfaction of the Seedy Solicitor.

The Jury, *after twenty minutes' deliberation, bring in a verdict of "Death from Misadventure while of Unsound Mind," and add a rider that persons and trains should not be allowed to cross the line at the same time, and further that deceased was guilty of great negligence in not getting out of the way of the train quicker.*

A.

Marriages.

O'MEARA—HOLLINGWORTH.—On August 23rd, at St. James's, West-end, by the Rev. Reginald Mortimer, rector of St. Mary Major, Exeter (uncle of the bridegroom), assisted by the Rev. C. R. Patey, vicar of the parish, Eugene John O'Meara, I.M.S., P.W.O. Bengal Lancers, eldest son of the late Dr. F. A. O'Meara, of Colyton, Devon, and grandson of the late Rev. Eugene O'Meara, M.A., of Newcastle, Dublin, to Gertrude Charlotte, third surviving daughter of the late Ollive Hollingworth, Esq., and granddaughter of the late Ollive Hollingworth, M.A., rector of Old Hollington, Sussex, and of the late Edward Wooles, Esq., Solicitor, Uxbridge.

STEVENS—REEVES.—On August 31st, at St. Peter's Church, Eltham Road, by the Rev. Richard Owen, M.A., Vicar, Thomas George Stevens, M.D. Lond., F.R.C.S. Eng., M.R.C.P. Lond., eldest son of G. J. B. Stevens, Esq., M.R.C.S. Eng., L.R.C.P. Lond., of Newington Green, N., to Lizzie, eldest daughter of John Reeves, Esq., of "Ecclesbourne," Eltham Road, Lee, S.E.

ED.—H. L. E.

Contents.

	PAGE
LAST HINTS ON BEDSIDE MEDICINE	373-375
PYLORECTOMY: Clinical Lecture by Mr. Dunn	375-379
SOME POINTS IN THE HISTORY OF THE HOSPITAL AND ITS MEDICAL SCHOOL	379-380
PAPERS BY GUY'S MEN	380
LECTURES FOR SESSIONS 1899-1900	381
THE SCIENCES: Anatomy and the Dissecting Room; Physiology; Biology; Chemistry and Physics; Practical Pharmacy, Materia Medica, Dispensing; Pharmacy, Pharmacology and Therapeutics; Medicine; The Medical Wards; Pathology; Bacteriology; Anæsthetics: Surgery; The Surgical Wards; Days and Hours of Attendance on Hospital Practice; Dental School	382-393
CORRESPONDENCE: Locum Tenens	394
CASE FOR DIAGNOSIS	394
PASSIM	395-397
NURSING NOTES	397
GUY'S HOSPITAL CLUBS' UNION: Constituent Institutions	398-404
CLUBS' UNION REPORT AND BALANCE SHEET	404-405
GUY'S HOSPITAL "BLUE"	405
IN LIGHTER VEIN	405-406
REVIEWS	406
FROM THE GAZETTE'S SPECIAL PATHOLOGIST	406
SPORT: Cricket	407
APPOINTMENTS	407-408
SOLUTION TO CASE FOR DIAGNOSIS	408

Calendar of Coming Events.

September, 1899.

Sat. 23.—Messrs. Howse and Jacobson's take-in; Drs. P. S. Mandy and A. Moon; Cl., A. A. Miller.
Hos.-Sch. C.C.—Lilies, home.

Tues. 26.—Examination for Entrance Scholarships begins.

Thur. 28.—Messrs. Davies-Colley and Symonds' take-in; Drs., B. Muir and E. F. Reeve; Cl., A. H. M. Saward.

Sat. 30.—Hos.-Scho. C.C.—North Brixton Gladstone, away.

October.

Mon. 2.—Winter Session begins.
First Meeting of the Physical Society at 8 p.m.
House Dinner at 6 p.m. Dr. Pye-Smith in the chair.

Tues. 3.—First Conjoint Examination begins.
First Part Camb. D.P.H. Examination begins.

Wed. 4.—1 p.m., Clinical lecture by Mr. Davies-Colley.
G.H.R.F.C., I.—Trial Game, home.
G.H.A.F.C., I. & II.—Trial Game, home.

Thur. 5.—Messrs. Lucas and Lane's take-in; Drs., Messrs. F. G. Gibson and F. G. Cross; Cl., E. Cohen.
Second Conjoint Examination begins.

Sat. 7.—1 p.m., Clinical lecture by Dr. Pitt.
G.H.R.F.C., I.—Kensington, away.
II.—Kensington, home.
III.—St. Paul's School, II., away.
IV.—Park House "C," away.
G.H.A.F.C., I. & II.—Trial Game, home.

Guy's Hospital Gazette,

SEPTEMBER 23, 1899.

Last Hints on Bedside Medicine.

IN seeing a patient, try to make out him first and his illness afterwards. Do not begin with percussion and auscultation, but hear what he has to say. The history is sometimes of great value, although often it is worthless, and now and again misleading. Most patients deny any previous illness, some assent to everything and many are too eager to tell their own tale for hem to attend to your questions. The most difficult thing is to get anyone to describe his own feelings, which no one else knows, instead of the names given to his complaints and their supposed origin. We have all learnt how ill-bred a thing it is to talk about oneself, but you will find that many patients will come to see you, not with expectation of useful advice or even of a cure, but for the pleasure of telling you about themselves and their families. For trustworthy history you must depend on re-examination and cross-examination and comparison of the patient's statements with those of *his* wife or *her* sister. Remember that "bronchitis" often means consumption; a "pain in the chest," a stomach-ache; "sun-stroke," syphilis; "rheumatic-gout," gout; "neuralgia," tooth-ache; "rheumatism," myalgia; "over-work," over-eating; and "mental worry," dram-drinking.

Let physical examination begin with inspection, go on to palpation, and end with auscultation. Look narrowly at the pupils, the great vessels of the neck, the hands, the lips, tongue and fauces. Feel the lymph-glands, particularly those at the angle of the jaw, the back of the neck and above the inner condyle of the humerus, and when you find an enlarged gland ask yourself whence come its afferent lymphatics. Look at the chest from above as well as in front and behind. Feel carefully the position, extent, force and strength of the heart's beat.

Train your ear to appreciate resonance and dulness accurately. Practise on your own chest. For standards refer to the abdomen for tympanites, the right axilla for pulmonary resonance, the forearm or thigh for complete dulness, and the shin for osteal dulness.

Remember that resonance is louder than dulness, that it is longer, lower pitched and more like a musical "tone," while dulness is fainter, shorter, higher pitched and a mere

"noise," and that "tympanitic dulness" is in feebleness, duration and pitch dull, but in presence of tone resonant. Remember that resonance spreads but dulness does not, so that emphysema and tympanites are apt to seem more extensive than they are, while the dulness of the heart and liver, of abdominal tumour and lobular pneumonia seem much less. Expect to find a large vomica dull, not resonant.

In auscultation learn to distinguish pulmonary (so-called "vesicular") breath sounds, however loud, "harsh," or "coarse" they may seem, from tubular (blowing, "bronchial," tracheal, laryngeal or amphoric), however faint or soft they may be. Remember that as a rule tubular breathing goes with dulness, bronchophony, and increased tactile fremitus, pulmonary breathing with resonance, and absence of breath sounds with dulness and absence of tactile fremitus. Of adventitious sounds be content, at least at first, to distinguish interrupted sounds (*râles*, "moist sounds," "rattles") made by bursting of bubbles, from continuous sounds (*rhonchi*, "dry sounds," whistling, cooing, snoring) made by a fluid vein. But of râles distinguish above all the "clear," "musical," "bright," "metallic," rattles, called "crepitant" or "consonating," from the toneless, "non-consonating" rattles. The former go with bronchial breathing and dulness, the latter with pulmonary murmur and resonance. Remember that rhonchi may often be mistaken for a dry pleuritic rub, and râles for a moist pleuritic rub. Never tamper with your auditory conscience by imagining physical signs to suit a probable diagnosis. With children auscultate after inspection, before percussion, and use immediate auscultation rather than the stethoscope.

It is more difficult to appreciate and explain the sounds of cardiac than those of pulmonary disease. Do not readily call a first sound "prolonged," or a second sound "accentuated" or "reduplicated." It is a venial error to overlook a faint or occasional murmur, a grave one to imagine a murmur which does not exist. The loudness of cardiac murmurs and their qualities (blowing, musical, saw-like, etc.) are of little consequence, their seat and their rhythm are all-important. Remember that a healthy heart will become irregular and give a loud systolic murmur if excited by bodily exertion or mental emotion, therefore give it time.

Before deciding that there is no murmur, listen after the patient has walked to and fro and when he is lying down. Make up your mind whether you mean by *systolic* and *diastolic* coincident with the ventricular systole and diastole respectively, or coincident with the first and the second sound respectively. The former is the older use of the words and is easier, the latter is the more modern, more minute but more liable to mistakes. To distinguish functional from organic murmurs, depend on their inconstancy, on their seat, and on the radial pulse, but not on their loudness or quality, and remember that they are systolic in rhythm, never diastolic or presystolic.

In examining the pulse, train your fingers to appreciate tension by the force needed to obliterate the artery, and test it by your own pulse and by a sphygmogram. Irregularity of force or of rhythm is important, intermission much less so, while frequency, force and apparent size of the vessel are apt to vary without apparent cause. Always check the indications of the pulse by those afforded by the heart, the temperature and the urine.

Never lay a cold hand on the abdomen. Use the flat not the tips of the fingers in palpation. In feeling the liver, spleen or kidneys, press up the loin on that side by the other hand. Do not forget to examine the testis and epididymis.

In all cases of abdominal tumour in women, think of pregnancy as possible; in all cases of vomiting, think of irritant poisoning; in all cases of cerebral symptoms, think of injury, of malingering and of intoxication, whether by alcohol, opium, or any other narcotic poison.

In cases of disease of the nervous system, separate hysteria from deliberate imposture, and toxic symptoms from both. Think of the muscles along with the motor nerves, and of cutaneous and trophic lesions with the sensory nerves. In the cord, localize the seat of disease, first in height, and secondly in breadth—*i.e.*, first by the "segments, and secondly by the tracts."

In the brain, after localizing as near as may be by physiological means, consider the probable "cause" or "nature" of the disease (rupture of a vessel, embolus, thrombus, injury, syphilis, tubercle, abscess), and then come back to the question of the seat with this help from pathological probability. Think of tabes, insular sclerosis and "general paralysis" as pathological allies, of fracture or caries of the spine and acute myelitis as clinical allies, and of the four pelvic symptoms in paraplegia—retention, incontinence, priapism, and bedsore as physiological allies.

In the same way think of gout as a pathological ally of granular kidneys, bad arteries, hypertrophied left ventricle and apoplexy; but as a clinical ally of traumatic arthritis, rheumatism, osteo-arthritis and gonorrhœal synovitis.

The distribution of lesions is a great practical help to diagnosis. Cancer affects epithelial structures only and travels by lymph-channels, sarcoma mesoblastic structures and travels by veins. Tuberculous disease of the lungs spreads from the apex downwards, pneumonia from the base upwards. Primary cancer very rarely affects the liver and scarcely ever the spleen. If we except typhoid and tuberculous ulceration and such mechanical lesions as hernia and invagination, the small intestines are almost free from disease, while the cæcum, colon and rectum are subject to all kinds. Abscess of the brain is never primary; nor abscess of the liver in this country; nor abscess of the lung except from pyæmia. Gout is almost always podagra, sometimes chiragra, seldom gonagra and scarcely ever omagra. Tubercle has a very extensive but rarely overpassed range. Syphilis may attack every organ and every tissue. Psoriasis is as unlikely to be found on the flexure of a joint as bears to be found in Africa, but eczema often leaves its proper territory as marsupials may occur in Virginia.

In a doubtful case of dermatitis, think firstly of its being caused by an irritant, intentional or accidental; secondly, by a drug; thirdly, by a parasite, and lastly, by syphilis.

In all cases make some diagnosis, but in difficult cases be satisfied at first with a provisional one: as, organic disease of the brain, the lungs, the heart, the liver, ascites, abdominal tumour, apoplexy, paraplegia, albuminuria or pyrexia.

In treatment be persevering, and push your remedies when your diagnosis is clear; be tentative and aim at symptoms when it is undecided. Inspire confidence, not by dogmatic assertions, but by sympathy and interest. Never give up a case, for where you cannot cure you can always relieve. Avoid giving minute diagnoses to the patient, but give him an English name for his complaint, carefully avoiding such phrases as "congestion" of brain, lungs or liver, "neurasthenia," "chronic rheumatism" and "suppressed gout" (unless you believe there are such things). To the nearest friend and to him or her alone, state your opinion more definitely and fully as to the nature and probable course of the illness. But reserve your diagnosis of the exact seat, the precise nature and the origin of the disease for your own notebook. Never make a false statement, but avoid such terrifying words as cancer, consumption and pernicious anæmia. Let your prognosis be as hopeful as possible, and when no other hope is left, hope that your diagnosis may, after all, be wrong.

As you practice your auscultation on your own chest, and recall your anatomy on your own joints, so from your own accidents or illness learn to sympathise with pain, to bear with impatience, and to put yourself into your patient's place.

P. H. PYE-SMITH.

Pylorectomy.

CLINICAL LECTURE BY MR. DUNN.

June 30th, 1899.

GENTLEMEN,—I am going this afternoon to talk about three cases of Pylorectomy. We operated on these cases for malignant disease of the pylorus. Of course, by pylorectomy we mean taking the pylorus right away—not only the pylorus itself, but any glands that are infected in the neighbourhood—and joining the duodenum on to the stomach.

Well, now, as I have already said, we did it in each of these three cases for malignant disease, and, of course, malignant disease of the pylorus, if left alone, must prove fatal. The history you will generally get in cases of pyloric cancer is that of vomiting and wasting. The patients will vomit, bringing up a large quantity about every second or third day, and if you ask them how much they bring up, they will say, "It is an enormous quantity, and I cannot think where it all comes from." They get a greatly dilated stomach, the stomach resonance on percussion sometimes reaching down to the iliac crest, and if you palpate the abdomen, the stomach contracts up under your hand and forms a great hard roll, which disappears when the contraction ceases. The patients will go on wasting and vomiting until they get so weak that they die after a comparatively short time. In these particular cases the patients were all wasted and elderly men.

Very often you find a swelling, which will be in the neighbourhood of the pylorus, just to the right of the middle line, which may be fixed or movable. If you detect any tumour on palpation, you may be quite sure it is rather a large mass, and if it moves, you can generally get it away, but if it is fixed, then it may be almost impossible to remove it, but you can never be

quite sure until you open the abdomen and look inside.

Well, now, in the first case I operated on, the man had lost three stone in weight; he was weak, his face was pale, he could scarcely get about at all, and was bringing up a quantity of brownish material that he had in his stomach. His age was fifty-six. I reported him in the "Guy's Hospital Reports," Vol. lii. I dare say most of you have read those reports. However, even if you have, I will just recall this case to your memory. I need say nothing about the man's history further than the remarks I have already made. He came in on the first of October, 1896, and I operated on the 9th. The operation was performed at 10.30 a.m. The A.C.E. mixture was administered, and a median incision four inches long was made just below the ensiform cartilage, towards the umbilicus. The peritoneum was rapidly reached and divided. I immediately discovered a hard, solid mass in the position of the pylorus, which was readily raised into the wound. There was no difficulty at all about finding the pylorus. Should any difficulty arise, a little gentle traction on the stomach towards the left will cause the mass to present at the wound. At this juncture the patient ceased to breathe. That happens very often during operations of this kind, and you have to be very careful about it. In this case we did artificial respiration, and the patient went on breathing again, and finally he settled down pretty comfortably, and we finished the operation without any further trouble. The mass was easily delivered from the wound, and it was found to be a malignant growth. The omenta attached to it were tied with silk ligatures, having been transfixed with an aneurysm needle in four places. When the mass was thus freed, strips of iodoform gauze were slipped down behind it, so as to cut it off from the peritoneal cavity as far as possible. We next took one of the clamps invented by Mr. Lane, and fixed it round the duodenum beyond the growth.

We then got the dresser to hold the stomach. He placed one hand above and the other below the stomach, and gripped it between the index and middle fingers of each hand, and then I cut with the scissors right through the stomach, half-an-inch to left of the growth. Then I turned the growth still attached to the duodenum out of the wound, and covered it over with iodoform gauze to treat subsequently. I then got the dresser to relax his fingers, and I made a puncture an inch and a half to the left of the cut margin on the anterior surface of the stomach, rather below the middle points, with a knife, and passed the forceps through there into the cavity of the stomach, and out again between the cut margins. The male portion of the Murphy's button was clipped in the forceps and drawn into the stomach, and made to project through the anterior puncture. After having done that, I sewed up the stomach. The same method was employed in all three cases, so I will read you how I describe this process:—"The mucous membrane, which was very thick and prolapsed, was inverted to a slight extent, and united by one continuous silk suture attached to a round sewing needle. This was made to pierce the submucous aspect of the mucous membrane on each side of the wound alternately, the direction of the needle being parallel to the long axis of the wound. A quarter of an inch of mucous membrane was transfixed at each puncture. The opposing peritoneal and muscular coats were then drawn securely together by a second continuous silk suture passed transversely to the long axis of the wound, the punctures being an eighth of an inch apart. Finally, this line was buried by approximating the peritoneal surfaces on each side of it, and retaining them in position by means of a third continuous suture inserted in the same manner as that closing the mucous membrane." After the suturing was finished, the stomach appeared to be perfectly watertight.

The next thing I did was to divide the duodenum beyond the growth, and then put the other portion of the button in. There was a little difficulty in this, because there was so small a part of the duodenum projecting beyond the clamp. However, after inserting a purse-string suture around the cut margin of the duodenum, the difficulty was overcome by removing the clamp. The parts exposed were then swabbed over with lysol lotion, and the two parts of the button were joined and pressed firmly home. We then sutured the abdominal wound up by three layers—the peritoneum first with a continuous silk suture, then the muscles with continuous silk, and then the skin with continuous horsehair suture.

I should have mentioned that the stomach was well washed out daily for three days previously, and that nothing was given by the mouth for twenty-four hours immediately preceding the operation, nutrient enemata being substituted. After the operation the patient progressed very well. He gave us no trouble whatever. He

was allowed just a little water by the mouth. There was no vomiting, and he did not cause us the slightest anxiety. At one period his pulse went up to about 120 per minute without any apparent reason. I thought the button was moving; it did move eventually, and on the 18th of June appeared at the anus. He got perfectly well, and went about his work for two years; he put on three stone in weight, and he used to come up as an out-patient just to show himself, and he never had the slightest pain, and was able to do his work and eat heartily without the least pain. He came up last October, and said he thought he was failing again. This was two years after the operation. I examined him, and found a most distinct swelling in the neighbourhood where the pylorus had been. I advised him to come in, and tried to get him into a private room, but two of these rooms were then under repair, and the third one was occupied. We waited till the patient got so ill that I was obliged to operate on him in the general wards. We washed out the stomach, took him to the theatre and operated rapidly. This time it was quite clear one could not remove the mass, and so I did gastro-jejunostomy, again making use of Murphy's button. He recovered from the shock of the operation, but commenced to vomit, which continued till he died on the third day after the operation. The post-mortem inspection showed that the jejunum had become acutely kinked at the button. There was recurrent growth at the junction of duodenum and stomach, which had also affected the hepatic flexure of the colon.

The next case was one of great interest. The patient was a man aged fifty-eight, and he came in with the usual symptoms—vomiting, pain and loss of flesh. I saw this patient with Dr. Bryant, who diagnosed pyloric carcinoma, and suggested operation. A large mass was easily palpable in the region of the pylorus. As the patient seemed in a fairly good condition, we decided to explore the abdomen. The operation was conducted on precisely the same lines as the one just recorded. When we had reached and were attempting to deliver the mass, the patient stopped breathing and turned a deathly colour. The anæsthetist found that his pulse had failed, and began to do artificial respiration. I passed my hand up under the diaphragm, and found no pulsation of the heart whatever. I grasped the heart through the diaphragm and squeezed it. It just gave a slight reaction, but it would not go on. I squeezed it a second time, and then it gave one beat, and still would not continue. It was not until I had squeezed it a third time that the rhythm returned.

After the pulse and breathing had been restored I decided to continue the operation, since it was clear the disease must soon prove fatal if left alone. His pulse and respiration settled down quietly so that we removed the mass without any difficulty. Just as we were going to adjust the button his respiration failed again, and I had to clamp the button together while they were doing artificial respiration. This made the clamping rather difficult to do, and I may not have pressed the button quite tightly enough. However, we sewed up the wound and dressed it in the usual way, and put the patient back to bed. He had a good pulse, and was breathing quite well. After the operation, as soon as he recovered consciousness, he began to vomit, and brought up a lot of bile; this continued for twenty-four hours and I felt very anxious about him, but his pulse never got up, and his temperature remained quite normal, and indeed he progressed quite satisfactorily. I omitted to mention one thing in connection with this operation, and that is that after washing out the stomach for the last time previous to the operation a large quantity of water was left in the organ, consequently a considerable quantity escaped when the stomach was divided and this probably soiled the margin of the wound. Owing to the size of the growth we had to cut so low down that we could not possibly put a clamp on the duodenum, and so we had to trust to good fortune that its contents did not escape.

We dressed the patient at the end of the week, and found the skin wound looking rather red. We removed the horse-hair suture and found the wound gaping a little. There was a little suppuration, not very much, and he went on comfortably. He did not put on the amount of weight that one would have liked him to do, and he never passed the button. We examined the rectum and palpated everywhere to try to find that button, but it was not to be found at all. Since then that man has been watching for it, and he cannot find it. We operated on February 10th, 1899; then he went out, and on March 25th continued pretty well. He used to come up from time to time to be dressed. There was a granulating wound in his abdomen, and the dresser had noticed that there was a little lump in the wound apart from the scar, and said he did not like the look of it, and he asked me to examine it. I thought it might be a stitch, but it grew larger, and it was clearly

not a stitch, so we readmitted him into the hospital. By this time the swelling had got to the size of a large marble, and it was rather to one side of the scar. We took him in on June 2nd, and operated for its removal. We found it to be a growth in the abdominal wall, and had no connection with the stomach whatever. The omentum (which we had turned up in front of the stomach at the previous operation) was quite free between it and the stomach. The growth was right up in the epigastric angle. We made an elliptical incision in the skin around it, and removed the mass together with the whole thickness of the abdominal parietes included in the incision. We could not possibly bring the parietes into contact, and so contented ourselves with uniting the edges of the skin, and shall trust to a belt to avoid a hernial protrusion. He is enjoying good health at present.

At the time of the operation I thought it a good opportunity to put the finger in and see whether I could find the button. I discovered an induration in the neighbourhood of the junction of the stomach and duodenum, and I think that is where it is. It is quite possible that during the artificial respiration I did not press the two portions of the button quite firmly enough together, and consequently it has remained *in situ*. I thought it wise not to interfere with it. That man is quite well so far; he eats his food and enjoys himself.

The third case is a still more interesting one. I operated in this case on the 5th of this month (June). He is an old patient, fifty-seven years of age, and he gave the usual history. I saw him in consultation with Dr. Shaw. He had an immensely dilated stomach; he brought up everything he had eaten for about two days previously, and had lost flesh markedly. He was a retired bricklayer, and was enjoying himself in the country when this came on. There was nothing to be felt except a greatly dilated stomach, and so we decided to explore. It might, we thought, be a fibrous stricture only. However, on opening the abdomen, quite a small growth tightly closing the pylorus was discovered. So small was it that we hardly knew whether it was a growth or not, until we found a regular chain of indurated glands along the great omentum; there was one large one, and then they got smaller and smaller. So we decided to remove the growth. What I did was this. I took out the large gland first, then the next one, and so on, until all the glands were removed, and some of the omental fat was plucked away in advance of the last perceptible gland to ensure complete removal. Then we operated in the same way as in the other cases. This patient did not stop breathing, his pulse did not fail, and he went on comfortably. I cut the stomach through with the scissors in the usual way. My dresser was clamping it, to prevent an outflow of the fluid. Then we turned the growth right out as before. I showed the section to Dr. Shaw, who thought that the cut margin of the posterior wall of the stomach looked rather indurated, so I took a further strip half-an-inch broad off the posterior surface. Four arteries had to be secured on dividing the stomach, otherwise the entire operation was conducted as before. During the process of suturing the stomach, the dresser held the stomach rather too tightly on the stretch for the continuous suture, and when he released his hold, the line of suture was seen to gape. This was noticed in time to prevent any leakage.

After the operation his temperature remained normal, and for ten days he went on perfectly well. He never vomited once, and we soon got him on to peptonised milk, and then to ordinary milk; of course for the first few days he was fed entirely by means of nutrient enemata. On the third day he experienced a good deal of pain, so much so that I could not help thinking one of the stitches must have given way; and that he had a little extravasation of the stomach contents. His pulse remained quiet, however, so we were not anxious, although at one time it was a question whether there was absence of liver dulness. He soon lost his pain, and said he never felt better in his life. On the 16th June his temperature was slightly raised, but there was no symptom of any consequence whatever. He was at this time able to eat chicken, sweetbread, and all sorts of things. His temperature kept fluctuating until it reached 101°, and on the 24th he had a rigor, and then we were beginning to wonder what was happening. At a later date the temperature reached 103°, and we began to think there must be something wrong. We went over his chest last Sunday, and found some dulness on the right side. We put an exploring needle in and found some pus, which was foul.

It was quite clear that the patient had a right-sided empyema, but we could not decide whether it had arisen from a subdiaphragmatic abscess, which had gone through the diaphragm and so into the pleural sac, or no. I told you he was a bricklayer; he was, moreover, a most obstinate man, and nothing would persuade him to have another anæsthetic—he was per-

fectly certain he would never come round. He was, of course, in rather a bad way, and it is difficult to open a man's chest without an anæsthetic. He still remained obdurate as regard general anæsthesia, so we injected eucaine, and made an incision, under great difficulty, into the pleural cavity. A large quantity of foul matter came out. We could introduce only quite a small drainage-tube as the ribs were so close together, and it was impossible to remove a portion of rib under the circumstances. He was very much shaken by the operation, and his temperature went up to 105° that night. He was better the next day, and the tube in his chest was discharging pretty freely. On the following day (Wednesday) we found that the discharge consisted of a large quantity of clear fluid, not pus, and then it occurred to us that this fluid was coming from his stomach. We tested it and found it acid. The wound, too, was looking very unhealthy. Well, then, it was difficult to know what to do. We decided not to give him anything by the mouth, and fed him upon nutrient enemata. He is not dead yet, but I am sorry to say that the left lung is getting blocked with mucus, and I consider him moribund. There is no doubt, I think, that if we can get an examination we shall find that the suture has given way, and whether it was because we held it too tightly stretched, or that we did not quite close the opening owing to taking another strip off the posterior wall I cannot say. I do not think the leakage was due to the button. The button came away on the 22nd perfectly well.

Now, there are, of course, many ways of doing pylorectomy. I have never seen anybody do it exactly like this before. I find that Mr. Murphy, who invented the button, has done a good many cases, and he always puts the button behind on the posterior aspect of the stomach. I find that it comes to hand rather better if the button is placed on the anterior aspect of the stomach, so that the line of suture is turned towards the posterior aspect. I think I shall in future, after this last experience, turn the suture to the front, as I am quite certain it is a bad thing to drain any abscess that may form through the pleural sac.

In all these cases I turned the great omentum upwards in front of the stomach, so that it lies in contact with the junction of the duodenum and stomach, and strengthens the union. It also tends to limit the extravasation should any occur. When, however, we look at this specimen the growth has recurred, and spreading down the upturned omentum has involved the hepatic flexure of the colon and produced a stricture, so that I think in future I shall leave the omentum alone. There are several other points I wished to allude to, but as our time has ended I must close my remarks.

Note.—The last patient died on June 30th. Only a partial post-mortem investigation was permitted. The peritoneal cavity was perfectly healthy. The duodenum was firmly adherent to the stomach, and it was very difficult to find the line of suturing in the stomach, so perfect had the closure been. All trace of malignant disease had been entirely removed. When the diaphragm was incised some pus was found in a localized cavity in the right pleural space. It was quite clear that the empyema had arisen quite apart from the peritoneum, and it was suggested that the inhalation of some material ejected from the stomach during the operation might have set up a localized gangrene of the lungs, and thus produced the empyema.

Some Points in the History of the Hospital and its Medical School.

THE HOSPITAL.

Guy's Hospital is approaching its two-hundredth birthday. Every Guy's man is expected to know something of the history of his hospital's long and glorious past in order that he may worthily maintain its ancient traditions. Almost all that can now be learnt about former times is faithfully recorded in the "Biographical History of Guy's Hospital,"* and in this place we can but give the barest outline of its development.

In the centre of the front quadrangle of the hospital stands the statue of our founder, Thomas Guy, around whose monument Guy's men have assembled from time immemorial on New Year's Eve to sing "Auld Lang Syne." Thomas Guy was a printer and publisher, a Member of Parliament, and a Governor of St. Thomas's Hospital, which in his time occupied the site on the opposite side of St. Thomas's Street. Grieved, it is said, by the spectacle of patients of St. Thomas's Hospital, barely convalescent from serious illnesses or accidents, discharged to make room for more urgent cases, he decided to provide an asylum to which they could be transferred until entirely restored to health. Guy's Hospital is the outcome of this benevolent idea, which though no longer carried out in its wards is more efficiently provided for by numerous convalescent homes along the coast and in pleasant rural districts.

Guy died on the 27th of December, 1724, and on the sixth of the following month the first 60 patients were

* "Biographical History of Guy's Hospital." By Wilks & Bettany. Ward, Lock, Bowden & Co. 1892.

admitted into the hospital which was built and endowed at his "sole costs and charges." So ample was the original endowment that in the first twenty years after Guy's death the governors were able to make three large and important additions to the buildings and to complete those portions of the hospital which are at present known as Guy's House or the Surgical Building, and the Clinical Wards.

About a hundred years later, William Hunt, an influential governor of the hospital, set an example which it is hoped may some day be followed by one of his successors. Impressed by the great work of charity carried out in the hospital, he determined to devote his fortune to extend its usefulness, and make his former fellow-governors his residuary legatees, whereby they became possessed of a sum of £180,000. This access of wealth enabled the governors to purchase the site and to build the great block which dwarfs Guy's original hospital, and is now known as Hunt's House, or the Medical Building. This work was not finally completed till 1871.

Not many years after the completion of Hunt's House, the remarkable depreciation in the value of agricultural land, which has had such a serious effect on property-holders throughout the kingdom, began to be felt by Guy's Hospital. After some years of financial embarrassment, the governors became convinced that the rental of their agricultural property would not for many years, if ever, rise to its former level, and determined to appeal to the public for pecuniary support. This appeal was repeated in 1895–96 under the auspices of the late Right Hon. W. E. Gladstone and of H.R.H. The Prince of Wales, the latter of whom became President of the hospital. A remarkable response was made to the appeal at its commencement, and the movement is being quietly yet actively continued, so that it is justifiable to regard the complete re-establishment of the fortunes of the hospital as within measurable distance.

THE MEDICAL SCHOOL.

At the time when Thomas Guy founded the hospital, medical education was a very different thing from what it is at the present day. A student, having spent three or four years as an apprentice to a medical man, entered a hospital as a pupil of one of its surgeons or physicians, and supplemented the knowledge that he had gained in general practice by watching the treatment of the patients in the wards. With an increasing number of pupils it became necessary to give systematic lectures, and such were first delivered in Guy's Hospital in 1769. This date may therefore be looked upon as that of the foundation of the medical school. Guy's did not become a complete medical school, however, till nearly sixty years later. From 1769 till 1825, St. Thomas's and Guy's hospitals provided conjointly for the education of their students, the pupils passing from one to the other to their lectures and classes, some subjects being dealt with in the older institution and others in the younger. During this period of union the course of study at the hospitals was lengthened, and there began in a small way that systematic teaching by lectures and practical classes which is such a striking feature of present-day medical education. When, therefore, the union was dissolved, and Guy's had to arrange for the complete instruction of its students, it became necessary to provide school buildings for that purpose. The first block of buildings was opened in 1826, and from that time to the present an increasing number of students and a multiplication of lectures, classes and demonstrations, have demanded almost constant additions of laboratories, theatres, and workrooms. The years in which the most important additions have been made are 1850, 1871, 1872, 1878, 1879, 1888, 1890, 1892 and 1897. It is interesting to note that the most recent addition to the school buildings—the new physiological department opened last year—is but the first instalment of a comprehensive scheme for rebuilding the whole medical school in a more modern and convenient style, so that it appears likely that in the future no less activity will be shown than in the past in keeping the accommodation abreast of the demands.

It is not upon its buildings but upon the scientific work done within its walls that Guy's bases its claim to a share in the making of the medical history of the world. The researches, teaching, and example of men like Astley Cooper, Bright, Addison, Gull, Wilks, Moxon, Fagge, Wooldridge, and many another less well known to fame have made the medical school of Guy's Hospital what it is. The opportunities of the student in modern days are greater than in the past, and it behoves each one to do his best, be it great or small, to add to the fame of his illustrious school.

Papers by Guy's Men.

On Anthropological work in Asylums, with a Practical Scheme for conducting the same in Adults. By Edwin Goodall, M.D., B.S., M.R.C.P. Lond.—*Lancet*, 15th July.

Micro-organisms in Dental Caries. By Kenneth W. Goadby, L.D.S. Eng.—*Transactions of the Odontological Society of Great Britain for June.*

Unilateral Castration for Prostatic Enlargement in a Man aged Eighty-seven Years: Atrophy of the Prostate. By H. W. Webber, M.D., M.S. Lond., and H. A. Duffett, F.R.C S. Eng.—*Lancet*, 12th August.

A Case of Puerperal Septicæmia treated with Anti-streptococcic Serum; Recovery. By C. T. B. Maisey, M.R.C.S., L.R.C.P. Lond.—*Lancet*, August 26th.

Preliminary Note on Some Experiments to Determine the Comparative Efficacy of the Different Constituents of Haffkine's Plague Prophylactic. By C. Balfour Stewart, M.A., M.B. Camb.—*British Medical Journal*, September 2nd.

An Inquiry into the Effects on the Blood and Urine of the Intravenous and Subcutaneous Injection of various Carbohydrates Standing in Relation to Animal Life. By Dr. Pavy.—*Journal of Physiology*, August 21st.

Lectures* for Sessions 1899–1900.

WINTER SESSION. OCTOBER—MARCH.

†	LECTURERS.		DAYS.					
Anatomy (1st & 2nd)	Mr. Clement Lucas and Mr. Lane	9	—	Tu	W	Th	Fri	—
Microscopical Pathology (3rd)	Mr. G. B. Smith and Mr. Pakes	9	—	Tu	—	—	Fri	—
Pathological Classes (3rd & 4th)	Dr. Shaw and Mr. Fripp	9.30	M	—	W	—	—	Sat
Bacteriology (Oct. & Nov.) (4th)	Dr. Washbourn and Mr. Pakes	9.30	M	Tu	—	—	Fri	—
Medical Jurisprudence (January) (3rd & 4th)	Dr. Stevenson	10	—	Tu	—	Th	—	Sat
Practical Obstetrics (3rd & 4th)	Mr. Targett (Oct.)	4	—	Tu	—	—	—	—
Chemical Physiology (Jan.) (2nd)	Dr. Starling, Dr. Beddard & Mr. Spriggs	10	—	—	—	—	Fri	—
Biology and Botany (pre. sci.)	Dr. Stevens	10.30	—	—	W	—	Fri	—
Chemistry (1st and pre. sci.)	Mr. Groves	12.15	—	Tu	—	Th	—	—
Practical Chemistry	Mr. Wade and Mr. Panting	10-12	—	Tu	—	Th	—	—
Advanced Practical Physiology (3rd)	Dr. Starling	11	M	—	W	—	—	—
Practical Medicine (3rd)	Mr. Cleveland	12	—	—	—	Th	—	—
Experimental Physics (pre. sci.)	Professor Reinold and Mr. Wade	12	M	—	—	—	Fri (2)	—
Chemical Physics (1st)	Professor Reinold	2	—	—	—	—	Fri	—
Practical Surgery (3rd)	Mr. McGavin	12	—	—	W	—	Fri	—
Physiology (2nd)	Dr. Washbourn and Dr. Starling	10	M	—	W	—	—	Sat
Clinical Medicine (3rd & 4th)	The Physicians	1	—	—	—	—	—	Sat
Surgery (3rd)	Mr. Howse and Mr. Davies-Colley	1.30	—	Tu	—	Th	Fri	—
Clinical Surgery (3rd & 4th)	The Surgeons	1.30	—	—	W	—	—	—
Elementary Biology (1st)	Dr. Stevens and Mr. Rowlands	2	M	—	—	Th	—	—
Mental Physiology (Oct. & Nov.) (3rd & 4th)	Dr. Savage and Dr. Hyslop	2	M	—	W	—	Fri	—
Morbid Anatomy (3rd & 4th)	Dr. Fawcett and Dr. Bryant	2.30	M	Tu	W	Th	Fri	Sat
Medicine (3rd)	Dr. Taylor and Dr. Hale White	4	M	—	W (3)	—	Fri	—
Ophthalmic Surgery (Jan.) (4th)	Mr. Higgens	3	—	—	W	—	—	—
Public Health (Jan.) (4th)	Dr. Sykes	4	M	—	—	—	Fri	—
Dental Surgery and Pathology	Mr. Newland-Pedley	4	—	—	—	Th	—	—
Metallurgy	Mr. Groves	4	M	—	—	—	—	—
Practical Dental Metallurgy	Mr. Hopson (Jan.)	3.30	—	Tu	—	—	—	—
Dental Anatomy & Physiology	Mr. Maggs	4.30	—	—	W	—	—	—
Dental Mechanics	Mr. Wynne Rouw (Oct.–Dec.)	4	—	Tu	—	—	—	—
Practical Dental Mechanics	Mr. Pillin (Jan.)	2.30	—	—	—	—	Fri	—

SUMMER SESSION. MAY—JULY.

†	LECTURERS.		DAYS.					
Midwifery (3rd)	Dr. Galabin and Dr. Horrocks	9	—	Tu	W	Th	—	—
Diseases of Women	Dr. Galabin	9	—	—	—	—	Fri	—
Pathology (3rd)	Dr. Pitt	9	—	—	—	—	—	Sat
Mental Diseases (3rd)	Dr. Savage	9.30	M	—	—	—	—	—
Microscopical Pathology (3rd)	Mr. G. B. Smith and Mr. Pakes	9	—	Tu	—	—	Fri	—
Bacteriology (May & June) (4th)	Dr. Washbourn	9.30	M	Tu	—	—	Fri	—
Practical Obstetrics (3rd)	Mr. Targett	4	—	Tu	—	—	—	—
Biology and Botany (pre. sci.)	Dr. Stevens	10.30	—	—	W	—	Fri	—
Histology (1st)	Dr. Starling, Dr. Beddard and Mr. Spriggs	9.30-12	M	—	W	—	Fri	—
Practical Medicine (3rd)	Mr. Cleveland	12	—	—	—	Th	—	—
Experimental Physics (pre. sci.)	Professor Reinold and Mr. Wade	12	M	—	—	—	Fri (2)	—
Clinical Medicine (3rd & 4th)	The Assistant Physicians	1.30	—	—	W	—	—	—
Clinical Surgery (3rd & 4th)	The Assistant Surgeons	1.15	—	—	—	—	Fri	—
Clinical Gynæcology (3rd)	Dr. Galabin	1.30	—	Tu	—	—	—	—
Morbid Anatomy (3rd & 4th)	Dr. Bryant and Dr. Fawcett	2.30	M	Tu	W	Th	Fri	Sat
Materia Medica (2nd)	Dr. Perry	4	M	—	W (3)	Th	—	—
Operative Dental Surgery	Mr. Badcock	11.45	—	—	—	—	—	Sat

* No effort has been made to include the many demonstrations or practical work.

† The numbers in this column refer to the years in which this course should be attended.

The Sciences.

ANATOMY AND THE DISSECTING ROOM.

How to begin Work.

THE first working day spent at Guy's Hospital is always a memorable event. There is a feeling of strangeness, which is quite natural. We are but vaguely conscious of what is to be done, and blissfully indifferent how to set about it. The very names of the subjects we have been told to learn convey no meaning, and the school buildings, with their various class-rooms and theatres, are an unexplored country through which we travel as in a maze.

For the help of the new men, it is proposed to give such instructions as they may need in beginning the work of their first winter session at Guy's. It will be assumed that they have already decided what the general course of their study is to be, that is briefly, whether they are going in for the Preliminary Scientific examination of the London University or not. Information on these matters is readily obtained at the medical school office, and any student who is not clear in his mind as to the examination he has to prepare for should read carefully page 70 in the green book.

After the first few days men soon become familiar with the work, and learn from one another. But at first they have made no acquaintances, and all around them are strangers alike.

Monday, October 2nd.—There is no actual work done on this day, but each student should pay his guinea for material in the medical school office, and take the receipt across to the dissecting-room and present it to the demonstrators. He should then study the red book—which contains the rules of the dissecting-room—and purchase some instruments and the other paraphernalia therein indicated. Any spare time is well spent in learning where the museums, class-rooms, and theatres are situated. The ground plan at the front of the green book will show them at a glance, and serve as a very efficient guide.

Tuesday, October 3rd.—At 9 o'clock in the morning the start is made, and we get our first introduction to the duties of hospital life at a lecture in the anatomical theatre, and at one o'clock a demonstration is given in the small theatre attached to the dissecting-room, both of which every new student is expected to attend.

To find a "part."

Look down the list of names on white cards which are suspended upon the wall of the dissecting-room opposite each subject or body. Be careful to take the proper side (right or left) which is allotted to you. If you fail to find your name on these cards, make yourself known and report the fact to one of the demonstrators present, who may be recognised by his white coat. The next thing is to obtain a bandage and cloth from the attendant (Hancock), who will be found in a room outside the dissecting-room. With these the "part" must be covered up at once to prevent the skin from drying. If the "part" is a limb, bandage it firmly from the hand or foot upwards as far as the bandage will go, and cover the remainder with a cloth, *but be careful to leave the metal ticket exposed to view.*

The Requisites for Dissection.

The following articles are essential, and must be purchased at once:—

a. Case of instruments. This should contain at least four knives, forceps, scissors, hooks, needle and blowpipe. Price 15s. to 18s., at Messrs. Down Bros., of St. Thomas's Street; or at Messrs. Hills & Co., of Newcomen Street; also from Hancock, the dissecting-room attendant.

b. Books. These are obtainable at Grattan's in the Borough, next door to the post-office. It is advisable to obtain either *Ellis's Demonstrations of Anatomy* (9s. 6d.), or, better, the more expensive *Cunningham's Practical Anatomy* (2 vols. 9s. 6d. each) for use in the dissecting-room, which show how to proceed and what is met with in the course of dissection; *and* one at least of the standard text-books, viz., Gray, Morris, or Quain. The inquirer will hear their merits compared at the introductory lecture and demonstration; if still in doubt he should consult personally one of the demonstrators, and take with him any old text-book he may possess for inspection and advice as to its use.

c. An apron and sleeves for the sake of protection and cleanliness. These are sold by Hancock. Any old coat may be worn under them. Instruments, books, apron and coat must be safely put away in a locker provided for the purpose; the key is obtained by making a deposit of 5s. at the medical school office. During the day hats and coats are kept at a special cloak-room near the dissecting-room.

d. A disarticulated skull and a half skeleton. (*See below.*)

How to Dissect.

The instructions given on this point in the text-books are by no means clear to one who has never done any dissecting in his life, and who does not know the meaning of half the scientific words in which the directions are given. He finds quite a new language in use, and no translation of it in the margin. Thus, he is told to "make an incision," instead of "cut"; to "reflect the integument," for "turn back the skin"; "anterior and posterior," instead of "in front and behind." Not a little of the difficulty and dulness attaching to anatomical descriptions depends on the need of a mental translation of the language in which they are written.

To deal fully with the skilful art of dissection is unnecessary here, and we will merely give such short directions as are needful for the work of the first two or three days. The objects of dissection are—firstly, to educate the sense of touch, and to teach the hand and the eye to work together in delicate manipulation; and secondly, to enable the student to see and handle the different structures that he reads about in his books. It is most decidedly not the object of dissection to lay bare the bone in the middle of the "part" in the shortest

possible time. That is butchery, not dissection. The following advice, then, may be given.

1. Cut through the skin along the lines given in the books.

2. Turn back *the skin only*, leaving the fat upon the body. This is done by holding the knife obliquely with its edge towards the skin.

3. Take away the fat carefully without damaging the dense white layer which covers the muscles.

4. Clean the surface of the muscle. To do this make the muscle taut by moving the limb, or pulling on it with hooks; then with the point of the knife clear away everything covering the muscle by working *with* its grain or fibre, *not* across the fibres.

5. Before taking any fresh step in your own dissection get a notion of the arrangement of the parts you are going to expose, either from another man's part, or from the wax model museum preparations.

6. Work very slowly at first. To turn back the skin carefully is quite enough to occupy the first day's work-time.

7. Cover the "part" up with a cloth before leaving it for the night.

The red book containing the rules of the dissecting-room will be found to contain a lot of useful information, which we give in full below, and should be read with care, and then kept always at hand.

OSTEOLOGY.

Usually considered a very dry subject; hence commonly studied in a stuffy museum after a heavy lunch with—the usual result. Like other branches of anatomy it must be learnt practically, by handling the bone, reading the description of it, and noting the various marks upon it, each one of which has its meaning. In order that the bones may be studied at home as well as at the hospital, it is very important that each student should possess them. Half-sets of osteology, that is, the bones of one side of the body with the spine and head, can be obtained second-hand at a very moderate outlay, and if carefully used they will at the end of the course readily fetch half the original cost, or even more. Some very useful half-sets (second-hand) are to be seen at Messrs. Millikin & Lawley's, 165, Strand, W.C., price 30s. If these are disposed of at the end of the second Conjoint examination for half the price, it follows that the immense advantage of having the bones always at hand while preparing for the examinations is obtainable at the expense of a few shillings.

In selecting a half-set of osteology it is well to have the guidance of a fellow-student who is familiar with them. See that the half-set is complete, and that each bone is of the *same* side. Avoid "the nice white bones," which dealers always charge extra for, and choose the rougher, better marked and dirtier ones. The preparation which makes them white, does away with many of the marks and ridges which have to be studied. With regard to the disarticulated skulls, try the separate bones and see whether they fit into each other properly, as it is not uncommon to find skulls offered for sale, the bones of which have come from different subjects, and hence cannot be articulated.

It may be necessary now that the "Bone" examination has been done away with at the College, to caution men against neglecting the subject during their first year. They will find the second year's work quite heavy enough as it is, and moreover may suffer the mortification of being spun in the Hospital Bone examination at the end of the first winter session, if they neglect the bones in their first month's work,

RULES OF THE DISSECTING-ROOM.

1. All first and second year's Students, and all those senior to the second year, who have not passed the Second Conjoint Examination, are expected to attend in the dissecting-room on the first day of the Winter Session, between the hours of 1 and 4 p.m., or on the second day between the hours of 10 a.m. and 12 noon. Each student must bring with him a voucher indicating that he has paid the special fee for material, which voucher must be handed to the demonstrator in order that the student's name may be enrolled in the appropriate class list.

2. The fee for material (which should be paid in the Medical School Office on or before the first day of the Winter Session, between the hours of 10 a.m. and 1 p.m.) is—

For each academic year:—

First Year's Students	25/-
Second Year's Students	
*Students Senior to the Second Year but not yet through the Second Conjoint Examination	
Students who have passed the Second Conjoint Examination and are now reading for the First F.R.C.S. or Int. M.B. ...	10/6
Students going up for the L.D.S. Examination only	
Students who enter during May (fee for the Summer Session only)	

3. The senior demonstrator (Mr. Steward) will meet the first year's students on the second day of the Session at 1 p.m., and give them a demonstration to initiate them into the work of the dissecting-room. Immediately after this demonstration parts will be allotted to students.

4. On the following day the Bone Classes, which are held by Mr. Fagge and Mr. Rowlands, begin. Every student must purchase a half skeleton and bring to the class the bone or bones which will form the subject of the demonstration. Regular attendance at these classes is compulsory until a student has passed in Elementary Anatomy. A student attending the class that is studying (A), (B), or (C), in Rule 8, will be allotted a part corresponding with the work of the class.

5. The senior demonstrator will meet the second year's students on the third day of the Session. The Second Conjoint Class demonstration given by

* This Fee must be paid by every such Student whether it is his intention to dissect or not.

Mr. Fagge and Mr. Rowlands begin early in the following week.

6. No student shall be enrolled in the Second Conjoint list or allowed to begin dissecting as a second year's student until he has passed in Elementary Anatomy and in Biology and Chemistry at the First Conjoint Examination.

7. The notice-boards in the dissecting-room should be examined daily throughout the Session. Here will be found class lists, notices of allotment of parts, announcements of vacancies for prosectors, arrangements for examinations, etc., and notices of alterations in standing arrangements. Every student's name should appear in one of these class lists, and any student failing to find his name should at once inform one of the demonstrators.

8. A written examination is held just before the Christmas Vacation. Every first year's student is required to attend and to answer the questions on one of the following groups:—

(A) The bones and ligaments of the head, and the bones, ligaments aud muscles of the upper extremity; or

(B) The bones and ligaments of the spinal column and thorax, and pelvis, and the bones, ligaments and muscles of the lower extremity; or

(C) (*if he is taking the L.D.S. only*) The bones and muscles of the head, and the temporo-maxillary, and occipito-atlanto-axoid joints.

Every second year's student is required to attend and to answer questions on—

The muscles, tendons, bones and ligaments of the whole body; and one of the following groups—

(α) The entire anatomy of the upper extremity and of the head and neck, including the brain and spinal cord; or

(β) The entire anatomy of the lower extremity and of the abdomen, pelvis and thorax; or

(γ) (*if he is taking the L.D.S. only*) The entire anatomy of the head and neck, excluding the brain.

9. A written Examination is held at the end of March. Every first year's student (except L.D.S.) is required to attend and to answer questions on the muscles, bones and ligaments of the entire subject. Every second year's student is required to attend and to answer questions on the anatomy of the entire subject.

10. The dissection of all parts allotted in October and November must be completed before Christmas, and on the second day after the recess new parts will be allotted, priority being given as far as possible to those students who showed themselves most painstaking in their previous work. A first year's student who, before Christmas, studied sub-division (A) in Rule 8, will now study sub-division (B); but in addition every student should, in this his second part, try to master as much as possible of the vessels, nerves, etc.

11. The senior demonstrator holds classes throughout the Winter and Summer Sessions for (i.) Students preparing for the First F.R.C.S. and M.B. Examinations of the various Universities; (ii.) Students who, though they have completed their second year, have not yet passed the Second Conjoint Examination.

12. Every student is advised to carry with him when in the Dissecting-room and Demonstration Theatre a pocket note-book and a set of coloured chalks.

13. Every week the dissections are examined systematically by the demonstrators, and marks are allotted. The record thus kept of each student's diligence in the Dissecting-room is taken into account in subsequently recommending to appointments in the wards.

14. A test examination is held about three weeks before each Second Conjoint Examination. Attendance at this examination is compulsory on all those who wish to present themselves for the Conjoint Examination.

15. During the first Summer Session, a student who entered in October, and has passed the Elementary Anatomy and the Biology of the First Conjoint Examination, should learn the anatomy of the brain, the spinal cord, the heart, the lungs, the larynx and the liver. Demonstrations on these subjects are given in the Demonstrating Theatre at least once a week during the Summer Session.

16. Particulars of the examinations for the Michael Harris, Arthur Durham and Hilton Prizes, and for the Prizes for General Proficiency, will be found in the Prospectus of the Medical School, which may be obtained in the Medical School Office.

17. About twelve prosectors to the lecturers on Anatomy are appointed annually (and from time to time a prosector to the Royal College of Surgeons of England) from among those students who have shown themselves most diligent in the dissecting-room. Notices inviting applications for these appointments are posted in the Dissecting-room.

18. The metal ticket attached to each part must on no account be allowed to come off nor to be covered up by the bandage that each student should apply to his part (if a limb); neglect of this rule renders the part liable to be forfeited. Apron and sleeves (2s. 6d.), bandages, cloths, air-pump, ointment, carbolic lotion, etc., can be obtained from the Dissecting-room porter.

19. No muscle, tendon, nerve, artery, or large vein, should be cut through, if by hooking it aside it is possible to reach and clean the parts lying on its deep surface.

20. No limb must be removed from the trunk except by one of the demonstrators or assistant demonstrators, nor in any circumstances must any part of a subject be removed from the Dissecting-room.

21. Except when the student responsible for a part is actually at work upon it, each part must rest constantly on the table of the subject to which it belongs. Neglect of this rule renders the part liable to be forfeited. When a student considers he has finished the part, he must report the fact to one of the demonstrators.

22. The subject is divided into five parts on each side:—

1. The Head and Neck.
2. Upper Extremity and Muscles connecting it with the Trunk.
3. Abdomen, with the Perinæum and interior of the Pelvis.
4. Lower Extremity.
5. The Thorax and Spinal Column; the dissection of which is not to commence until the fourteenth working day.

23. Students are not permitted to exchange or dispose of their parts, either before or after the commencement of dissection.

24. Any part, the dissection of which has not been begun within twenty-four hours from the time when the body is placed in the Dissecting-room, is liable to forfeiture. If a student is unable to continue the dissection of the part which he has already begun, he must give notice *in writing* to one of the demonstrators, who will make arrangements for its disposal. The demonstrators will also dispose of any part, the dissection of which has been discontinued without their sanction for more than two working days.

25. The subject when brought in will be placed in the supine position, and will so remain during nine working days. On the tenth day a majority of the students engaged upon it, and on the fourteenth day any one of them, may have it turned into the prone position. Five days later it may, if the majority so desire, be turned back again; and after six days in the prone position any one of the dissectors may have it turned back. The time for the dissection of the perinæum is before 11 a.m. on the first ten days, and neither for this purpose nor for any other must the subject be turned out of the position indicated in this rule.

26. The Dissecting-room is open from 9 a.m. till 4.30 p.m., except on Saturdays, when it is closed at 2 p.m.

27. On applying at the Medical Office a locker may be obtained for a deposit of Five Shillings (which will be returned when the key is given up, provided that the locker is uninjured).

N.B.—The Anatomy part of the First Conjoint Examination has now ceased to be held at the Royal College of Surgeons, and its place is taken by an examination held at the Hospital in two parts—one just before the Christmas and the other just before the Easter recess.—*Vide* Rules 8 and 9.

DENTAL STUDENTS.

During their first winter session dental students are expected to dissect the head and neck and to study the bones and muscles of the head with the temporo-maxillary and cervical articulations upon which they are examined at Christmas. In addition, they should become acquainted with the main vessels, nerves, and special structures of these regions.

A dental student, on entry, must pay the fee for material at the Medical School Office, on October 1st, between 10 a.m. and 1 p.m., so that a part may be allotted to him at the earliest opportunity. He should obtain a copy of the rules of the dissecting-room, and study those paragraphs which specially concern him. He should be careful not to miss the demonstration given by Mr. Steward to first year's students, on Wednesday, October 4th, at 1 p.m.

Special bone classes are held for dental men, commencing early in November, the times of which will be duly announced on the notice-board in the dissecting-room.

It is very essential that the study of anatomy, physiology, and surgery should be prosecuted energetically from the outset, thus obviating the necessity for "cramming" these subjects when preparing for the final L.D.S. examination. Careful and patient dissection is the easiest way to learn Anatomy. An attempt to "cram" it from books is certain to result in disaster.

PHYSIOLOGY.

Physiology, which treats of the workings of the healthy body, and forms, therefore, the institutes of medicine and the necessary foundation of any rational mode of treatment of the body in disease, differs from its sister subject, Anatomy, in that it requires much greater intellectual efforts for its acquisition, and a more thorough preliminary training for the comprehension of its doctrines. Physiology, in effect, consists in the application of the natural laws elicited by the researches of physicists and chemists to the explanation and description of its phenomena occurring in the living body, so that an acquaintance with the chief laws of physics and chemistry forms the necessary basis for the study of physiology. The difficulty and importance of this subject would seem to indicate, in the clearest possible manner, the necessity of pursuing its study throughout the short space of two years, which are devoted to the subjects that are preliminary to the work in the wards. Nevertheless, in consequence of the inept regulations of the bodies which govern the medical curriculum, six months of this precious time is wasted in acquiring a worthless smattering of something dignified by the title of biology. On this account, the student beginning his medical studies in October must give all his energies to getting up his biology in order to pass in it at the earliest possible opportunity, although he may profitably combine with the biology lectures and classes the reading of some elementary work on physiology, such as Huxley's *Elementary Physiology*, or the smaller work on the same subject by Foster and Shore. He is not advised to attend the physiology lectures at this time, and will not be signed up for them.

By the ordinary student the study of the subjects included under the heading Physiology is begun in the first summer session. During the whole of this session he must attend the classes in Practical Histology. These are held in the students' histological class-room

three times a week; each class lasts two hours, the first half-hour being taken up by a short lecture, in which the tissues to be studied in the following practical work are described. This lecture will be held in the physiological theatre. Students attending this course must provide themselves with a compound microscope,* certain mounting materials (a list of which can be obtained at the office), and with Schäfer's *Essentials of Histology*, which should be carefully studied in the intervals between the classes. The microscope must have two objectives, a $\frac{2}{3}$-inch and a $\frac{1}{6}$-inch, a nose-piece and an indicator fitted to one of the two eye-pieces. The following makers are recommended: Crouch, Zeiss, Ross, Leitz (English agent, Kanthack), Swift. From any of these latter firms a good microscope, with all necessary accessories, can be obtained for about £7; the microscope from inferior makers is worse than useless, and it is essential that the student should buy an instrument which will be of some use to him in future years, when as a practitioner of medicine he desires to examine tumours, urinary sediments, sputum, etc., for purposes of diagnosis.

At the end of the summer session an examination, written and practical, is held in histology. All students who have attended this class must enter for the examination. Only those who pass the examination will be allowed to attend the tutorial classes in physiology held during the second winter session in preparation for the examinations of the Conjoint Board. Those who fail at this examination will be allowed to enter for a similar examination at the following Christmas, but will not be able to present themselves for the second Conjoint under six months from the time at which they passed this examination.

During the second winter session the student must attend regularly the lectures on physiology held three times a week, on Mondays, Wednesdays, and Saturdays at 10 a.m. During the same time those who have passed the histology examination at the end of the previous session must attend the tutorial classes held by one of the demonstrators throughout the session. At the same time he must read up the subjects in some elementary text-book, such as Starling's *Elements of Human Physiology*, or Kirke's *Hand-book of Physiology*.

During the second half of the winter session, *i.e.*, from January to March, students must attend the class in practical chemical physiology, which is held once a week in the physiological chemical class-room. While attending this class, they are recommended to read up the subject in Halliburton's *Essentials of Chemical Physiology*, which is also used as the guide in the practical work.

Students who have been diligent in following this course of studies will be ready to enter for the second Conjoint examination at the end of this session. Shortly before this examination, a test examination is held by the demonstrators in order to judge of the fitness of the candidates. Those who fail to pass the second Conjoint at this time must attend the revision classes held by the demonstrators during the two or three months preceding the July and January examinations of the Conjoint Board.

*The demonstrators will be very pleased to advise any student in the purchase of a microscope. It must be distinctly understood that antiquated instruments, such as those sometimes handed down as an heirloom in a family of doctors, are absolutely useless.

Certain modifications in this course of studies is necessary for those who are going up for the M.B. of London or other Universities. Having passed their preliminary scientific before entering, they are free of the incubus of biology during their first winter session. They should therefore attend the physiological lectures during this session, at the same time studying the subject in Starling's *Physiology*. In their first summer they attend the histology classes, but should supplement Schäfer's *Essentials of Histology* by reading the fuller accounts of the subject contained in Quain's *Anatomy*. During their second winter, they should attend the class in advanced practical physiology, which is held twice a week, each lesson occupying between two and three hours. During this session they are recommended to read up the subject in Stewart's *Manual of Physiology* and Bunge's *Physiological Chemistry*, using Halliburton's *Essentials of Chemical Physiology* and Brodie's *Essentials of Experimental Physiology* as the guides in the advanced practical physiology. This class should also be attended by candidates for the first F.R.C.S. examination, although in their case attendance may often be profitably postponed until the third winter session. The reading for this examination is similar to that required for the Intermediate M.B. of London.

Those who are desirous of obtaining honours at the Intermediate M.B. should supplement the course of reading already indicated with original papers in the *Journal of Physiology*, and with parts of Gamgee's *Physiological Chemistry*. Such students will also find parts of Foster's *Physiology* extremely useful and suggestive.

Revision classes are held by the demonstrators during the two months preceding the first F.R.C.S. and first M.B. examinations for the special preparation of candidates for these examinations.

List of books recommended:—

FOR COLLEGE MEN.—Schäfer's Essentials of Histology; Starling's Elements of Human Physiology; Halliburton's Essentials of Chemical Physiology.

FOR LONDON MEN.—Stewart's Manual of Human Physiology; Bunge's Lectures on Physiological Chemistry; Histological and Embryological parts of Quain's Anatomy.

E. H. S.

BIOLOGY.

The Course of lectures and demonstrations for the requirements of students preparing for the first Conjoint examination is given in the long room, class room No. 2, at 2 p.m., Mondays and Thursdays. The practical class will be held immediately after the lecture, and the new student is reminded that it is most important for him to attend both lecture and practical class from the

very first, to obtain the knowledge in biology requisite for the Conjoint examination. The very closest attention to his work, more especially *in the practical part*, is necessary if the pupil would become familiar with a subject which, seemingly of not much value to him now, will be of no inconsiderable assistance in later work, particularly in the domain of morbid histology and bacteriology.

The first lecture will be given by Dr. Stevens, in the long room, class room No 2, on *Wednesday, October 4th.* For the practical class, the requisites, of which a complete list is given below, must be obtained *beforehand.* We recommend new men, with reference to the purchase of a microscope—perhaps the most important consideration on entering these classes—that it should be deferred until one of the demonstrators has been consulted. We may state that microscopes are not absolutely necessary for the early classes, so that the purchase of one may be safely withheld until full instructions have been received from the demonstrators.

The special course of lectures and demonstrations devoted to the Preliminary Scientific examination of London are held on Wednesdays and Fridays at 10.30 a.m. The first lecture will be given by Dr. Willey on Wednesday, October 4th, in the biological class-room, No. 4, on the first floor of the pathological museum block of buildings. "Pre. Sci." men will require the set of requisites that are notified below.

With regard to this list, we have already referred to the "microscope." In purchasing a "dissecting case," students must understand that an ordinary (human) anatomical set is *all* that is required. The special "biological set" is by no means necessary for the elementary work required at Guy's, and is, therefore, a needless expense.

Requisites for the Practical Biology Class.

Every student attending these classes must provide himself with a microscope fitted with a double nose-piece. Crouch's student's microscope with $\frac{2}{3}$rds and $\frac{1}{6}$th objectives, two eye-pieces and a double nose-piece, in mahogany case, price about £7 10s., is strongly recommended. It can be obtained from Mr. Crouch himself, or from Maw, Son & Thompson, Aldersgate Street. If a foreign pattern of microscope is preferred, Zeiss's or Leitz's is to be recommended, and can be obtained of Stanley, London Bridge; R. Kanthack, 21, Golden Square, Regent Street, W., or of Baker, High Holborn. These microscopes are slightly more expensive than Crouch's. It will be necessary also to have a stoppered bottle (with glass rod) containing Canada Balsam, dissolved in xylol; a stoppered bottle containing xylol; three small white saucers with flat bottoms; three watch-glasses ground on convex surface; two section lifters; three needles in handles; a pair of microscope scissors (curved on the flat); $\frac{1}{2}$-oz. No. 1 $\frac{3}{4}$-inch cover glasses; a gross of glass slides; a packet of labels: a small piece of soft silk; fine curved forceps; a "Seeker"; an anatomical dissecting case; a razor for cutting sections.

S.

CHEMISTRY AND PHYSICS.

It is impossible to acquire a knowledge of chemistry or physics without personal and practical contact, and Guy's men have, in the new laboratories, unusual facilities for this purpose.

Conjoint men entering now should pass in chemistry and physics next Easter, and should therefore attend the lectures in chemistry from October to March (Mr. Groves Tuesday and Thursday at 12.15), and the lectures on physics from October to Christmas (Prof. Reinold, Friday at 2). They must be prepared to devote a large amount of time to laboratory work. The practical classes are held in the chemical laboratory twice a week (Mr. Wade and Mr. Richmond, Tuesday and Thursday from 10 to 12), but students have access to their benches at all hours, and are advised to make free use of this privilege, if they wish to make satisfactory progress. The first class of the new session will commence at *10 a.m.* on *Tuesday, October 3rd*, when *all Conjoint Students* should attend; the first lecture follows at 12.15. Revision classes are held before the April examination, and special classes for referred candidates before those in January and July; admission to these classes is dependent on the student passing the monthly test examinations in a satisfactory manner.

Conjoint students are not required to study chemistry or physics after passing the first examination, unless they wish to take the diploma in public health, in which case they work for three months at the analysis of water, air, food, etc., in the public health laboratory (Mr. Pakes).

Dental students under the new regulations are required to go through the same course as the Conjoint men, and to pass the first Conjoint examination, but those under the old regulations need only attend the lectures and a three months' practical course (Mr. Richmond, January to March).

Special courses have been arranged for most of the University examinations. Candidates for the Preliminary Scientific (M.B.) examination of the London University attend, during the first half of the winter session, the same chemistry lectures as the Conjoint men, but the physics lectures are specially arranged (Prof. Reinold, Monday at 12, Friday at 2). The Preliminary Scientific class meets for work twice weekly in the chemical laboratory (Mr. Wade and Mr. Richmond, winter and summer, Tuesday and Thursday 10 to 12), and twice weekly in the No. 1 physical laboratory (Mr. Richmond: winter, Tuesday 2 to 4, Friday 3 to 4; summer, Monday and Thursday 2 to 4); but students are expected to spend all their spare time in one or other of the laboratories. It cannot be too often or too strongly urged that reading without laboratory work is mere waste of time. Tutorial classes are held weekly in both chemistry and physics, and are supplemented by revision classes during the term preceding each examination, and by monthly test examinations. Students intending to work for Honours in either subject should consult the demonstrators. A new and extended syllabus, both for Honours and for Pass, is now in operation.

Intermediate M.B. men who have just passed the Prel. Sci. should begin to work at organic chemistry not later than next May, or earlier if there is room in the laboratory; men who think of working for Honours, or who intend to take the B.Sc. in chemistry should start at once. The attention of candidates is drawn to the recent radical alterations in the syllabus, and especially to the fact that the practical examination now includes the preparation and recognition of typical organic compounds. The practical class meets twice weekly in the laboratory throughout the year (Mr. Wade: winter, Monday and Thursday 2 to 4; summer, Tuesday and Thursday 9 to 12); and is supplemented by lectures, revision classes, and monthly test examinations. A course of experimental lectures for beginners will commence on October 7th (Mr. Wade, Chemical Theatre, 10), and will be continued through the winter.

Students intending to present themselves for the Inter. M.B. next July* should have worked in the laboratory for nine months by that time, those who attended the course last summer, for instance, requiring to work for four months this winter and two months again next summer. Candidates for Honours next July should, of course, resume laboratory work at once.

Oxford, Cambridge or Durham students desiring to work at chemistry should communicate with the demonstrators.

The practical knowledge of toxicology required at the degree examinations of the London and other Universities may be obtained at classes held by Mr. Wade and Mr. Richmond during the latter part of the winter and summer sessions. W.

PRACTICAL PHARMACY. MATERIA MEDICA. DISPENSING.

These subjects are taught in the practical pharmacy class at the hospital dispensary, by Mr. Collier. This course meets the requirements of students preparing for the Conjoint examination in practical pharmacy, and the intermediate M.B. Lond. The study of the names, physical characters, and chemical properties of substances used in medicine, and preparations made from them, and the doses in which they may be given, requires some considerable amount of application and exercise of memory. The instruction given in the class is therefore very practical, and every assistance is given to the student by demonstrations, access to materia medica specimens, and *viva voce* examinations, in acquiring a sound knowledge of materia medica. The art of dispensing, the writing of prescriptions, and the methods of prescribing drugs, form also part of the instruction given in the practical pharmacy class. During the year there are three courses of three months each, so that the student can enter at the time most convenient to him.

* The examination now commences on the *first Monday in July.*

PHARMACY, PHARMACOLOGY AND THERAPEUTICS.

Lectures are given during the summer session in the anatomical theatre, by Dr. Perry. This course is intended to meet the requirements of students preparing for the third Conjoint examination in pharmacology and therapeutics, for the intermediate M.B. and final M.B. Lond., and the third M.B. Cambridge. C.

MEDICINE.

Medicine lectures are held on Mondays and Fridays, at 4 p.m., and Wednesdays at 3 p.m., in the anatomical theatre, throughout the winter session, by Dr. Taylor and Dr. Hale White. The introductory lecture will be given by Dr. Taylor, on Wednesday, October 4th, who will then proceed to discuss "Fever, Contagion, and Specific Diseases."

A clinical lecture is delivered every Saturday, at 1.15 p.m., in the physiological theatre, the first of which will be given by Dr. Pitt, on Saturday, October 7th. These lectures are held at 1 p.m., so as to enable footballers to attend, and they finish in time for them to catch the 2.23 train to Honor Oak Park.

In addition to the above course, Dr. Bryant holds revision classes for six weeks before the final Conjoint examinations in January, April, and July, for the benefit of students desirous of presenting themselves for the final examination in Medicine.

THE MEDICAL WARDS.

Clinical instruction in medicine is given in the medical wards to the medical ward clerks and other students who choose to be present, by the physicians, who visit their cases from 2 to 5 p.m., and by the medical registrar in the mornings from 10 a.m. to 1 p.m. There are two male wards, Philip and Stephen, each containing forty beds, and one female ward, Mary, containing fifty beds and six cots. The latter is divided into four divisions, each physician taking one division. Dr. Taylor and Dr. Hale White divide the beds in Philip ward between them, and Dr. Pitt and Dr. Perry those in Stephen ward. On Mondays and Thursdays the wards are visited in the afternoon by all the physicians; on Tuesdays by Dr. Hale White and Dr. Pitt; on Fridays by Dr. Taylor, Dr. Hale White and Dr. Perry; and on Saturdays by Dr. Pitt. The medical registrar sees new cases in all the wards on Monday and Thursday mornings; on Tuesday Dr. Taylor's cases; on Wednesday Dr, Pitt's; on Friday Dr. Hale White's; and on Saturday Dr. Perry's. Thirty-six medical ward clerks are appointed every three months, and are eligible for reappointment at the end of this time for a further period of three months, the extension being given to those who have shown the most care and diligence in the discharge of their duties.

1. *Case-taking.*—Reports are made by the medical ward clerks on all the cases admitted to the wards, under the supervision of the medical registrar, who instructs

the clerks in the mornings in the method of case-taking, and the physical examination of patients. Special report sheets are kept for this purpose in the wards; on the front page, spaces for the name, age, occupation, address of patient, ward, number of bed, physician, date and references to former admissions, if any, must be filled in; the report itself must be then started on the next page, by recording the most prominent symptoms for which the patient was admitted, *e.g.*, "The patient was admitted for hæmoptysis, ascites, or vomiting," as the case may be. If the patient has been an in-patient before, the old report must be looked up in the registrar's room, which is in the new building, on the right-hand side of the stairs, leading to the medical wards, the key of this room being hung up behind the door of the Eye wards opposite. Since the year 1888, an index of all the patients' names has been made a separate volume for each year, and they will be found in this room on the table. Having found the patient's name, a letter and a number will be found after it; the former is the initial letter of the physician, the latter the number of the report in that physician's volume of reports for that year, *e.g.*, if a patient had been in the medical wards in 1890, and the name is found in the index with P.S. 100, after it, it would mean that he was under Dr. Pye-Smith, and his report would be number 100 in Dr. Pye-Smith's volume of reports for 1890. The clinical reports for the year are all bound together, and the letter C refers to the clinical volume. If the patient has been in the hospital before, during the current year, his report can be obtained by applying to the medical registrar. If he comes under the same physician the report must be continued; if under a different physician, an extract must be made and a new report commenced. Before the year 1888 an index of names will be found at the commencement of each volume.

The old report having been found, an extract must be made, and the diagnosis then arrived at inserted in the new report. The condition of the patient since his last discharge from the hospital must then be noted; then the commencement of the present illness, with the symptoms and the date (not the name of the day only) of their onset, and the treatment before admission Supposing there had been no previous admission, after stating the leading symptoms for which the patient was admitted, a description of his previous manner of life, occupation, travels, etc., must be noted; then his family history, especially in diseases of the nervous system, gout, rheumatism, phthisis, etc., then a history of previous illnesses, with dates, and then of his present illness, as above described; and lastly, the condition on admission. This last-mentioned is the most important, and should be done as soon as possible. If the clerk has not seen the case on admission, the necessary details may be obtained from the house-physician. The condition on admission should be commenced by noting the pulse and respiration rate, and the temperature and general appearance of the patient; this should be followed by a description of the system primarily affected, then the system most likely to be affected by complications, *e.g.*, in a case of acute rheumatism first describe the articular, then the circulatory, respiratory, cutaneous, alimentary and nervous systems. When describing physical signs the results of the examination should be arranged as far as possible under the headings Inspection, Palpation, Percussion and Auscultation, and it should always be remembered to use the eyes before the hands, and the hands before the stethoscope. In acute cases a daily record of the physical signs, symptoms, and the general condition of the patient must be kept. In renal cases a daily examination of the urine must be made and the result noted on charts provided for this purpose. In all cases the treatment written on the bed-letters must be copied into the reports. Observations made by the physicians on their rounds should be reported, great care being taken not to misinterpret them.

When the patient leaves the hospital a description of his condition on the day of discharge must be noted, and the report concluded with a short epitome of the leading features of the case. If the patient dies, an abstract of the post-mortem report, which can be obtained in the post-mortem room, must be inserted. When the report is completed, it must be taken to the medical registrar's room.

2. *Temperatures.*—The temperature of the patients must be taken and noted every morning by their respective clerks. Evening temperatures are taken by the clerks in turn; the dates of this duty will be found on the notice-board in the central hall of Mary ward. The temperatures to be taken will be put on a card hanging on the wall in each division.

3. *Classes.*—On Thursdays, classes are held for all the medical ward clerks at 12 o'clock, in the surgical class room, on the application of anatomy to medicine, the methods of medical diagnosis, and the explanation and interpretation of physical signs. On Mondays, at 12.15, classes are held in the chemical laboratory for Dr. Pitt's and Dr. Hale-White's clerks; and on Tuesdays, at 2 o'clock, for Dr. Taylor's and Dr. Perry's clerks, when practical demonstrations on the examination of urine, blood, sputum, etc., and on the use of the various instruments required for clinical investigations are given by the medical registrar.

4. *Beds.*—The arrangement of beds will be found on the notice-board in Mary ward.

5. *The Clinical Laboratory* (door opposite the lift in the new building), is open to medical ward clerks between 10 and 1, for any special clinical investigation and for the examination of sputum. The key can be obtained from the medical registrar, to whom also application for any special apparatus or reagents must be made.

6. *Medical instruments.* — Instruments for clinical investigations — hæmocytometer, hæmoglobinometer, perimeter, spectroscope—are under the charge of the medical registrar, and can be obtained from him on application.

7. Four clinical assistants are appointed every three months, commencing February, May, August and November, from those students who have already held the appointment of medical ward clerk. It is their duty to aid the junior ward clerks in the preparation of their reports, to assist the registrar, and to carry out and superintend clinical investigations required by the physicians.

A few practical hints:—Medical ward clerks should, first of all, make themselves familiar with the normal physical signs, *e.g.*, the normal shape of the chest, the normal vesicular murmur, the normal cardiac sounds, etc., and then with the physical signs of disease, their mode of production and their special import. It will be found useful, first of all, to read a book on physical diagnosis, such as Hutchison and Rainey's *Clinical Methods*, or Gibson and Russell's *Outlines of Physical Diagnosis*.

As a text-book Taylor's *Medicine* cannot be improved upon. Do not start at the first page and read straight through, but read up and endeavour to understand your own cases. When this has been done, use your colleague's cases in the same manner. *Do not be rough with your patients; percuss and palpate gently. Do not sit up a patient suffering from typhoid to examine his back. Do not percuss the chest of a patient suffering from hæmoptysis. Do not test the knee-jerks of a patient suffering from acute rheumatism; and if you sit on his bed, look before you sit. Do not discuss with your colleagues in the patient's hearing the prognosis of the case if it be serious, or the probable post-mortem appearances of his organs. Remember that your patient is ill, and imagine yourself in like position. You will then treat him with the kindness and consideration he deserves.*

M. R.

PATHOLOGY.

The large number of courses of instruction in pathology given in the school leads to some uncertainty in the student's mind as to the order and period of the curriculum in which they should be taken. Pathology is one of the few good things of which it is impossible to have too much, and probably the best advice that can be given to a student who has passed his second Conjoint or Intermediate M.B. is to take the instruction in pathology which is offered to him as early and often as possible. Most of the instruction in pathology is given in the early morning so that it shall clash as little as possible with work in the wards, and it is rarely advisable to postpone attending a course till the time arrives, which many seem to expect but fortunately seldom reach, when ward duties shall be less exacting than they are at first. A man who leaves the dissecting-room in April should begin to attend Dr. Pitt's systematic lectures on pathology in the following summer session (Anatomical theatre, Saturdays at 9) where he will be introduced to the great principles underlying pathological processes, and will learn something of the theories of disease, which will enable him to understand the facts revealed to him in the post-mortem room. He should remember that this course of lectures is not completed in one year, and that if he attends the lectures for three consecutive years he will each time hear different subjects treated of. If it is in the summer session that a student is released from his anatomical studies, he should begin to learn pathology at the winter demonstrations (Dr. Shaw and Mr. Fripp, Monday, Wednesday and Saturday, 9.30, in class-room No. 2). Here he will be introduced to the treasures of the pathological museum. Selected specimens will be brought from the shelves of the museum for his inspection, and the effects of pathological changes upon the various organs of the body will be demonstrated. The subject is roughly divided into medical and surgical pathology, two days a week being devoted to the former and one to the latter. The whole course occupies two years. At the end of each half-hour demonstration on museum preparations, a *viva-voce* examination is held on typical recent specimens collected from the post-mortem room and operating theatre.

Valuable as is the instruction afforded by these systematic lectures and demonstrations they must on no account be allowed to take the place of the daily demonstrations of Morbid Anatomy (Dr. Bryant and Dr. Fawcett, 2 p.m.) in the post-mortem room. Here a student gains information on the relative distribution of morbid processes throughout the body, and learns to verify the accuracy of his observations at the bedside. No ward clerk must on any account neglect to follow the fatal cases to the post-mortem room, and throughout a student's career there is probably no more profitable way of spending an afternoon unappropriated to routine duty than in watching post-mortem examinations. It is not always possible to find time to hold the appointment of post-mortem clerk, but whenever it is the appointment should be held. The man who misses the opportunity while he is at the hospital of becoming acquainted with the many difficulties that may be encountered in making a post-mortem is sure to regret it afterwards.

The practical use of the microscope in solely pathological problems should be learnt as early as possible. With this object the course of Microscopical Pathology (Mr. Bellingham Smith and Mr. Pakes, Tuesday and Friday at 9 in the New Histological Laboratory) should be attended in the first winter session after the student gets into the wards. Here he will gain his first instruction in practical Bacteriology, which he will have constant opportunities of making use of in the wards. Here he will also amplify the knowledge he has already acquired, in the course of Normal Histology, of section cutting and staining, and have demonstrated to him the microscopical appearances of tumours and diseased tissues. A man cannot often find time to attend this course more than once, but he should attend it early in his career and work hard to learn enough about technique to enable him to afterwards examine specimens that constantly come in his way while holding senior appointments. Morbid histology and bacteriology

are very engrossing studies, and many good men fight shy of them on account of the amount of time they fear they will "waste" over them. But a man of method can generally find a good many spare moments to devote to this work without seriously interfering with his reading, and he who acquires the hobby will find it a useful one to ride when he has accomplished his examinations and is waiting for patients.

BACTERIOLOGY.

The compulsory course in bacteriology forms part of that in microscopical pathology. This year, as last year, the first two months will be occupied with this subject. The rudiments of the science are taught; the methods of staining sputum, pus, etc., to demonstrate bacteria; the methods of collection of morbid products for bacteriological investigation; in fact the technique of the examinations which can be undertaken in the wards.

Two optional courses are also held. These form part of the course for the D.P.H. Examinations, but may be taken quite independently of that examination.

These begin in October and May respectively, and last for upwards of two months. This course consists of lectures and demonstrations which include the morphology and life-history of the pathogenic germs and the disease to which they give rise; the examination of morbid secretions and excretions, water, air, protozoa, etc.; susceptibility, immunity, etc. The students are instructed in the practical details of media making, culture, staining etc., and they examine the more common pathogenic and non-pathogenic bacteria.

ANÆSTHETICS.

Lectures and demonstrations are given by Mr. Tom Bird and Mr. Rowell on the use and administration of anæsthetics; they are open to men who have passed the Second Conjoint examination or its equivalent, and to dental students in their second year. The post of "anæsthetic clerk," of one month's duration, is open to students only who have attended the lectures and demonstrations.

SURGERY.

Lectures are held three times a week, on Tuesdays, Thursdays and Fridays, in the anatomical theatre, by Mr. Howse (1.30) or Mr. Davies-Colley (9.30). Mr. Howse for the first part will lecture on "General Surgery," commencing on Thursday, October 5th. Clinical lectures are given on Wednesdays, at 1.30 in the anatomical theatre, by the surgeons. The first will probably be given by Mr. Howse, on Wednesday, October 4th.

Mr. Dunn, six weeks before the final Conjoint examinations in January, April and July will hold "Revision Classes," upon which attendance is voluntary. Only those desiring to present themselves for examination are expected to attend.

Mr. Dunn will hold a course of "Operative Surgery" for final M.B. and Fellowship men in October, of which further notice will be given. The course for the requirements of the Conjoint Board will be held in January, 1900, and the fee of 10s. 6d. should be paid not later than December 18th. Names of students desirous of attending the M.B. course should be left at the medical office *before* the end of September. Mr. Higgens will lecture during January to March on "Ophthalmic Surgery," on Wednesday, at 3 p.m., in the ophthalmic operating theatre. The lectures must be attended after passing the second Conjoint examination before admission to the final Conjoint.

THE SURGICAL WARDS.

In the surgical wards there is a division of labour, and corresponding to this division, the appointments fall into two classes—clerking and dressing. The student's first introduction to clinical work is as a clerk in the surgical wards, and it is not unlikely that he may, on his first entry, be a trifle discouraged. The reasons for this are obvious. Entirely ignorant of surgery and even of the terms in common use, he is at once required to write full accounts of the cases admitted to the wards. He will find, however, that by paying attention to the advice we give him, that his difficulties will be found to be anything but insurmountable.

Being the junior appointment in the hospital, there a tendency in the minds of some, and a little more than a tendency in the minds of others to belittle the post. This is unjust, and is the result of ignorance of the real functions of the surgical clerk. What the medical clerk is to the medical side, the surgical clerk is to the surgical side. The post is junior in point of time, but does not necessarily carry with it any stigma of inferiority. Their duties are identical: the preparation of the permanent hospital records of the cases admitted to the wards. What difference there is consists in this; the machinery of the medical side is less complicated than that on the surgical; whereas the whole of the work in the medical wards falls on the clerk, in the surgical wards it has been found advisable to specialise and to separate—for the sake of greater proficiency—the duties of clerking and dressing. This separation has, on the whole, been justified by the results, the chief difficulty being the dependency of the clerk on the dresser for many details of importance. Dressers should, therefore, remember that from them the hospital expects such assistance as will render the reports as complete as they can be made. On the clerk, however, rests the responsibility, and the excellence of his reports is a sure indication of smooth working and mutual assistance in the firm to which he belongs.

The recent appointment of an overseer to each firm of clerks in the person of a clinical assistant in the surgical wards has been of inestimable value, primarily to the clerks, secondarily to the whole firm. The clinical assistant should be the immediate "ear" of all his clerks, to instruct them of their duties in the wards, also relieving the surgical registrar of many details in the filling in omissions of the reports of his firm.

We do not wish to exalt the clerk unduly, but to insist merely that in his work the same care and attention to detail, the same knowledge of surgery and human nature are as necessary as in other appointments. Let him bear in mind that to him is given by the hospital the task of keeping its records. These are bound and kept, and by his work thus perpetually in evidence a man is judged. Bad reports are a lasting disgrace; good reports a lasting honour. The importance of good careful work by the clerks cannot be over-estimated. In the nature of things it cannot be perfect, but it must be as perfect as he can make it. By his first work in the wards he will be judged, and he will find that it is very hard to live down a bad clerkship. At the same time that he bears in mind the difficulties and responsibilities of his post, he should remember that he is a junior, and that any assistance he can lend his seniors should be offered ungrudgingly, and in return for this he will undoubtedly meet with that consolation and help in his work which is so necessary. There is no loss of dignity sustained in carrying screens to patients, or in the thousand and one small opportunities which present themselves of helping the other workers in the wards.

To the dressers we would submit that the performance of dressing is no part of the clerk's duty, and that it is no kindness to him to request him to undertake what he cannot from his position with good grace refuse, and what nevertheless he is unfitted to do.

The work of the firm, as a whole, should be the interest of each individual member of it. Pride should be taken not only in its splinting and dressing, but also in its reporting. A good house-surgeon and a good dresser will see that the reports are not below the level of those of other firms, for as they represent the work of the firm the individual members should see that they give a fair and accurate idea of that work. The clerk, aided by the clinical assistant, from this point of view is to be regarded as the mouthpiece of the firm to succeeding generations. The firm should see that he represents it fairly.

The clerk, as soon as he is appointed, should find out from the surgical registrar to whom he is appointed A few days before taking over the work he should learn from his predecessor what he can about the cases he is to take charge of, so that the work may be continued as nearly as possible without a break. At the present time there is an entire change of clerks every three months, but in the way indicated above, the break in the work may be obviated to some extent. He should learn quickly to take accurate temperatures, and pulse and respiration rates, and test urine, for without any exception the temperature, pulse and respiration rates, and condition of the urine must be included in the notes of every case on admission. The surgical registrar sees every new case with the clerk on the morning after admission, when he expects a history of every case to be ready. This, if vague, is useless. All symptoms should be set down in exact order, with the dates of their appearance. The exactness in detail is of the highest importance, and is a measure of the care with which the clerk has done his work.

He should have a note-book, and should put down in it everything about the case that he can obtain from the surgeon, house-surgeon, clinical assistant, and dresser. This should be copied into the report as soon as possible. We would impress on each clerk the value of seeing everything done by the dressers or house-surgeons—the operations, putting up fractures, especially when done at night in take-in week, and this should apply to manipulations on every case under the surgeon, and not only to the cases which the individual clerk has to report—as much may be learnt in this way which otherwise can only later be gathered with much greater effort.

A new departure was made last year in the Practical Surgery Classes, which are in the hands of the Surgical Registrar, who gives four courses a year, each beginning on the appointment of the new surgical ward clerks, and especially designed for their instruction in all matters relating to that appointment.

Lists of the duties appertaining to each appointment are supplied to the students, and these are to be carefully followed out. The hospital not only expects this, but insists on it. We have laid stress so far on the appointment of surgical ward clerk, as it is the first post that the student holds, and because he is so often quite unaware of the objects of the appointment.

He will in time become a dresser, and will by that time have learnt the traditions that underlie his office. He should, before accepting office, have acquired most thoroughly the principles of aseptic surgery, and, on no account, ever depart from them subsequently. Let soap and water be his sheet anchor.

The surgical wards are visited every day by the surgeons and assistant surgeons at 1.45. Tuesdays and Fridays are reserved for operations, notice of which has been posted in the colonnade. The surgeons are assisted at the operations by the dressers, and no others should stand about the well of the theatre, the only exception being the particular ward clerk to the case. With due diffidence we should like to hint that the front seats reserved for the staff and for visitors were never intended to be used as a footstool. The habit of sitting perched along the front rail is one of recent growth only, and in the interest of the patient, the operator, and those watching the operation is to be deprecated.

Although we believe there is no rule which prevents freshmen attending operations and clinical demonstrations, we would point out that such a course of action is useless to them, and is not encouraged by the authorities.

Finally, we should like to repeat that although specialization has provided a clerk responsible for the drawing up of the hospital records, yet as this report is an account of the work performed by the firm as a whole, it touches the honour of everyone in it that the report should be an accurate statement of the work done. The firm should be considered the entity, each separate member of which fulfils his own function, each at the

same time being dependent on the others for the smooth, even working of the whole. S. R.

DAYS AND HOURS OF ATTENDANCE ON HOSPITAL PRACTICE.

Accidents and urgent cases of all kinds are admitted by the St. Thomas's Street entrance at any time of the day or night.

THE WARDS.

Medical Wards.—Dr. Taylor (1.30), Mondays, Thursdays, and Fridays. Dr. Hale White (1.30) Mondays, Tuesdays, Thursdays, and Fridays. Dr. Pitt (1.30), Tuesdays, Thursdays, and Saturdays. Dr. Perry (1.30), Mondays, Thursdays, and Fridays.

Surgical Wards.—Mr. Howse (1.30), Mondays and Thursdays. Mr. Davies-Colley (1.30), Mondays and Thursdays. Mr. Lucas (1.30), Mondays and Thursdays. Mr. Golding-Bird (1.30), Mondays and Thursdays. Operations (1.30), Tuesdays and Fridays.

Obstetric Ward.—Dr. Galabin (1.30), Mondays and Fridays. Dr. Horrocks (1.30), Tuesdays and Fridays.

Ophthalmic.—Mr. Higgens (1.30), Fridays. Mr. Brailey (1.30), Tuesdays. Operations (1.30), Mondays and Thursdays.

THE OUT-PATIENT DEPARTMENT.

The days and hours of attendance in the Out-Patient Department of the hospital are as follows:—

Medical Cases.—Dr. Shaw (12.30), Fridays. Dr. Washbourn (12.30), Wednesdays. Dr. Bryant (12.30), Mondays.

Surgical Cases.—Mr. Jacobson (12.30), Wednesdays. Mr. Symonds (12.30), Thursdays. Mr. Lane (12.30), Mondays. Mr. Dunn (12.30), Saturdays.

Obstetric. — Mr. Targett (12.30), Thursdays and Saturdays.

Ophthalmic.—Mr. Higgens (1.30), Tuesdays. Mr. Brailey (1.30), Tuesdays and Fridays.

Dental.—The Dental Staff (9), every week-day.

Aural.—Mr. Purves (1), Tuesdays.

Skin.—Dr. Perry (1), Tuesdays.

Throat.—Mr. Symonds (2), Fridays.

Electricity.—Dr. Bryant (1.30), Wednesdays and Thursdays.

DENTAL SCHOOL.

The dental student is supplied at the medical office with the Prospectus, Standing Orders, Notes on Probationary Work, List of Instruments, Calendar, and Clubs' Union Book.

If these pamphlets are carefully perused the student will become well acquainted with the general arrangements of the school, and the scope of the work upon which he will be engaged during his studentship.

It will first be necessary for him to purchase his instruments at one of the dental depôts, and to satisfy himself that he has been supplied with all of those described in the hospital list.

Probationary work upon the phantom head will occupy the freshman's time for about two months. This operative course is conducted by the staff demonstrators, and it is very comprehensive, as it includes most of the conservative operations that the student will subsequently perform on patients, namely gold and other fillings, crowns, inlays, and the treatment of devitalized and septic teeth. If the manipulations upon the dummy are done in a thoroughly sound manner, a capital ground work of operative dentistry will be acquired. It may be mentioned in passing that too much stress can scarcely be laid upon the necessity of becoming an expert operator, for the public are not slow to appreciate the highest manipulative skill.

The regulations of the Royal College of Surgeons of England requires that dental students, who registered on and after January 1st, 1897, shall pass two professional examinations for the dental license. At the first professional examination a certificate must be produced, *inter alia*, of having manufactured and adjusted six dentures and six crowns.

Inasmuch as it is recommended at Guy's that this examination be passed during the month of May, it follows that the first winter session must be largely devoted to dental mechanics, demonstrations, and lectures.

The student is advised to do his dissections early in the session. His time will be less occupied at this period, and he cannot then be the means of conveying septic infection from the dissecting room to patients, which might possibly occur if dissections were deferred until he is permitted to operate upon the living subject.

All available spare time can be profitably spent in the Out-patients' department, surgical and dental. Notes and models of interesting cases should be made and reported to the Dental Society.

The industrious man of average ability will find his time well occupied if he spends two years only at the hospital—the minimum period demanded by the Royal College of Surgeons. The facilities at Guy's are unsurpassed, for it is the only hospital in London where all the special and general lectures can be attended, and the practical work done.

The library is open to all students, and it contains the standard medical and dental works, and the current periodical literature. Reference books can here be consulted, and many of the books can be borrowed under certain necessary restrictions.

The advantage of joining the Clubs' Union are great, and a composition fee admits a student to the privilege of membership to all the constituent institutions. Some of the societies included in the Union are intended for the training of the mind, whilst others aim at the development of the body.

It is with justifiable pride that Guy's men strive to excel in sports, and it is hoped that dental students will materially help to bring laurels to the hospital.

If a student needs help or advice in his work he is recommended to consult the Dean, or any member of the Staff, any one of whom will gladly do what he can for the best interests of the student.

M.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Locum Tenens.

The Editor cannot hold himself responsible for the opinions expressed or the advice tendered in the following letters.

SIR,—As a contrast to Terence's and one or two other of your correspondents, my experience of Locum Tenens has been a singularly happy one.

The last three or four have been supplied me by Mr. C. H. Wells, of Guy's Hospital Office, and now connected with the Agency. I write to him several weeks before the time I wish to start my holidays, and mention that I really wish for a reliable man, and am willing to pay more than the usual fee (then £3 3s.) if this will secure a good man.

They were all Guy's men, and could be fitly described "Gentlemen."

I make a rule of introducing my L. T. to one or two of my professional colleagues in this town, and to visit the more important cases on my list, etc., and then depart leaving him my address. My household, I believe, do their best to attend upon him and make the house comfortable. On our return I have invariably found that the patients have been well pleased and satisfied, also the Locum expresses himself similarly.

Having always left behind me satisfactory and able men, I now find that my patients have not the rooted aversion to allowing the L. T. to attend upon them that there seems to be experienced in many practices.

I should be glad to welcome any one of the men who has taken my work, if I were going away; nearly all of them are in practices of their own now.

Hoping Sir, that I shall not have to trouble you in the course of a year or two with a sequel of Further Experiences of the genus L. T.—I remain, yours faithfully,

Retford, Notts, Sept., 1899. J. M. T.

SIR,—I have been much amused by the Locum Tenens discussion; but one fact seems to have been lost sight of, and that is, that medical practitioners, recently qualified and seniors, may be divided into two classes—gentlemen and otherwise. Now, if Locum is a gentleman and is sent to the house and practice of otherwise, the result is probably unpleasant to Locums. Conversely if otherwise is sent to look after a gentleman's practice and live in his house, the consequences are hardly likely to please the aforesaid G. P.

As an old Guy's man—1870 to 1874—my opinion is, having been the employed and employer many times, that there is quite as much to be said on one side as on the other.

The curse of our profession is the number of bounders who enter it.

Some little tradesman, or person of that class, gets money together and "means to make 'is boy a gentleman." He makes him into a doctor; but the early home influence is seldom eradicated, and the result is not a credit to the medical profession.—Yours truly.

September 16th, 1899. COCKATOO.

Case for Diagnosis.

Arthur F., æt. 15, ten days before admission, appeared to be in his usual health; he then ate some green apples before going to bed and was seized at 1 a.m. with vomiting and some pain in the right side; at the same time he was feverish but had no rigor. On the following day he saw a doctor, who diagnosed gastro-enteritis, and ordered him to remain in bed on a milk diet. For the next four days the boy continued feverish and had some diarrhœa, but he was not sick. Afterwards, however, the vomiting recommenced, and though the diarrhœa ceased his condition became worse, and he was sent up to the hospital nine days from the beginning of the illness; he had not been noticed to cough.

On admission, the temperature was 101·6°, the pulse 120 and running, respirations 40, shallow and regular. The face was flushed, the eyes sunken, skin hot and dry, tongue dry and coated with brownish fur; there was no delirium and patient had no pain. The lower part of the right chest was bulged out somewhat, and the intercostal spaces were filled out; there was absolute dulness over this part of the chest, the percussion note beginning to be impaired at the level of the nipple in front and at the fourth rib in the axillary line, the upper limit stretching round behind in practically a straight line. Below, the liver dulness ceased at the costal margin and the liver could not be felt; tactile vocal fremitus was present except at the extreme base; the cardiac impulse was in the left nipple line. On auscultation a few consonating râles were heard just above the dull area, and behind the voice sounds approached ægophony at this level, while there was well-marked bronchial breathing over the upper part of the dull area; in front the breath sounds were absent. The abdomen moved on respiration; there was some tenderness on pressure just below the right costal margin. The boy had two years previously been treated for an attack of typhlitis, and before that for tuberculous disease of the tarsus; otherwise he had had good health. Stimulant treatment was adopted and patient was twice sponged during the twenty-four hours after admission, as the temperature exceeded 104°. About thirty hours after admission vomiting came on and lasted for about four hours, when it stopped; a few hours later patient became very collapsed; he was cold and almost pulseless and sweated profusely, and the temperature dropped in four hours from 103·8° to 95·6°. Stimulants were pushed and the boy got better; the chest was explored with a needle, but nothing was withdrawn. During the next twenty hours the temperature rose steadily to 103·6° when patient died, vomiting having occurred for some hours previously accompanied by diarrhœa.

(*For post-mortem result see page 408.*)

Passim.

Every October sees a new year begin at Guy's with the advent of many strangers. To those who have chosen this as their hospital we give a very hearty welcome, for they have chosen well and we are glad to see them. They have come to a very pleasant place, teeming with human interest, full of good fellows and good women, and full of opportunities for showing the best qualities of a man. The only thing we would impress upon them is that they should make good use of their time.

In saying this we do not mean to preach or utter platitudes of the ordinary educational kind. There is more to do at Guy's than merely to work for examinations and gain medals. If at the end of his time a man leaves the hospital and is remembered afterwards as a good companion and a true friend, his career has been worth more to him, and he has done better than if he went out into the world unregretted, though laden with technical honours.

The hospital and the world at large judge men differently. Here of necessity a man's worth is usually judged by success of the mercantile sort, honours, medals, and all the conventional rewards of the industrious apprentice. These men are seldom those who make the real successes in after-life ; for dealing with men and women, especially in times of sickness and trial, many other qualities are needed besides pure erudition ; sympathy, personal attraction, and a knowledge of human nature will make a man's life a more solid joy to him than the possession of all the laurel wreaths of Burlington House.

But while here be wise in your generation and work. The possession of a quick mind and a ready wit seldom goes with a capacity for work, and in the race for supremacy at the hospital the workers generally win. So we counsel work, always emphasizing the fact that long hours of inattentive reading are not equal to shorter periods of more acute mental advance. To quote Sir Francis Bacon, "Therefore measure not *Dispatch* by the Times of Sitting, but by the Advancement of the Businesse."

The Annual House Dinner will be held in the Dining Hall on Monday, October 2nd, at 2 p.m. Dr. Pye-Smith has kindly consented to take the chair, and Mr. Cosmo Bonsor has also signified his intention of being present.

The dinner will be followed by the Physical Society's Meeting, when a paper will be read by Dr. Wheelton Hind on "Geology as a Hobby." Sir Samuel Wilks will take the chair. The paper will be followed by a Conversazione and the usual exhibition of specimens, instruments and books.

We would remind all Guy's men, both present and past, that though they may not have received a personal invitation to be present, they are most earnestly invited to attend and will be heartily welcomed. One's first evening at Guy's, and the meeting of the Physical Society, is usually very deeply impressed upon one's memory, and it is a good thing to occasionally revisit old scenes and meet old faces.

One word to those men now entering who are intent on distinguishing themselves on the football field. They may be quite sure of receiving a real and hearty welcome, and we would at once direct their attention to the Captain's letter in our sport column. Nothing that we can say could do more to stimulate their zeal. To those who prefer a somewhat less violent form of exercise we would say, "Try cross-country running." This pastime has always been popular at Guy's, seeing that for the last eight or nine years we have had no difficulty in winning the Inter-hospital Cup, and as a sport it has certainly pleasures which improve on closer acquaintance. There is now plenty of room for new talent, and the Secretary will be only too pleased to hear of any.

The Rugby Secretary writes :—"The experiment of playing two trial games proved so successful last year that it is proposed to repeat it this season. The first game will be played on Saturday afternoon, September 30th; the second on Wednesday, October 4th. Freshmen are urged to turn out on both occasions, as there are likely to be vacancies in the team, and a good impression created early in the season is always to the advantage of a new player."

With the present number of the Gazette we are publishing two illustrations, one of Dr. Pye-Smith and the other of the Rugby Football Team, who this year won the Inter-Hospital

Cup for the second time, after its absence from Guy's for eleven years.

DR. PYE-SMITH'S photograph is in the nature of a memento, for unfortunately he has just retired, and the hospital is the poorer for his loss. Happily, however, Dr. Pye-Smith has not quite severed his connection with the hospital, as he has consented, for the present at least, to remain President of the Students' Club.

FRAMED copies of Dr. Pye-Smith's photograph can be seen in the Hospital Library, and any men desirous of having their copies so framed should leave their orders with the Librarian.

THE successor to Dr. E. H. Starling is still unappointed, and the post of Physiology is at present vacant. In the interval, however, Dr. Starling has kindly offered to go on lecturing, and will for the present superintend the Physiology department. A successor to Mr. Minchin has been found in the person of Dr. Willey, who will commence lecturing on Biology at the beginning of the session. Mr. Minchin, by the way, like Dr. Starling, has left Guy's for University College, where he has been elected to the Chair of Zoology in the place of Professor Welldon, who has gone to Oxford.

ON the resignation of Dr. Panting, Mr. B. A. Richmond has been appointed Assistant Demonstrator of Chemistry and Physics.

IT is sincerely to be hoped that last year's *fiascos* in the matter of smoking concerts will not be repeated. A few years ago, within the memory of the present generation, the Guy's smoking concerts were recognised as among the best in London. Last year, from sheer slackness, there were no concerts at all. If only men who can sing, play, or amuse in any way, unconsciously or otherwise, will come forward and offer their services to any of the Residents, the latter will be extremely grateful. It is obviously impossible for the Residents to come round to all the new men and ask them personally and individually. Modesty must be put aside for the occasion, and men must advertise their own merits.

WE have before us the prospectus of the Brinklea Sanatorium at Bournemouth for the Open-air Treatment of Consumption. The question of sanatoria for phthisis has been brought very prominently before the notice of the medical profession in the last year or two, chiefly from the very successful published results of the better known German establishments, such as Nordrach and Falkenstein. It is very generally acknowledged, however, that climate is not so much the essential point as the method of treatment, and any English establishment which gets a reasonable amount of sunshine is quite equal to the continental resorts. In this respect Bournemouth is very suitable for such an institution, which should prove most successful. The Sanatorium is under the medical supervision of Dr. A. Kinsey-Morgan, of Bournemouth, himself an old Guy's man.

THE average man in the hospital is very long-suffering, and not prone to go further in the matter of complaining than vicarious literary efforts in the Suggestion Book. At the present time, however, most of the Residents in the College have just cause for complaint in the rather unsatisfactory state of the catering department. The dining hall is exceedingly well managed in some respects, the arrangements of the table and the linen are beyond reproach, and the waiting is on the average good, but at present, at any rate, improvement in the fare is possible and necessary. More than this we will not specify, but hope for the best. The matter would probably have never got into these columns but for the fact that nobody seems to know who are on the catering committee, and contrary to custom there is no list of that Committee on the notice-board in the smoking-room at the present time.

IT is absolutely necessary that only men who are college residents should be elected to the catering committee. Men who only come in for luncheon do not realize the sufferings of the habitué, who takes all his meals in the dining-hall day after day. These are the men on whom monotony and fibrous tissue begin to pall, and they are more fit to represent the grievances of the men.

THE present appointment list looks rather meagre. This list does not accurately represent the position of affairs, as the vacancies for dressers, clinical assistants in the medical wards, and other appointments, will not be filled up till next month, as we announced in the last issue of the GAZETTE. However, with

P. W. Pye-Smith

G. Jerrard, Photo. *A. Couchman, Coll.*

the five years' curriculum and entries less than they were four or five years ago, the ever-increasing number of appointments makes it more difficult to fill the very large list every three months. In this respect, men of this generation are more fortunate than their predecessors, as appointments which were formerly most difficult to get, owing to the competition, are now almost to be had for the asking—that is, unless the petitioner has an absolutely criminal record.

Two notable names are evident in the list. Mr. C. H. Fagge has been rewarded with extension in the Ear Department, and Mr. H. J. Starling comes amongst us again as a Dresser in Throats. Such a practised vocalist as Mr. Starling ought to make his mark in the throat department. We suggest he should popularise the operation for the excision of the *vibrato* in the young adult.

The Debating Society promises to have a very successful season. It is still under the able guidance of Mr. Brydone, who was so largely responsible for its sudden revival last year, after being in a moribund condition for some years previously.

It is proposed, we understand, this year to have some of the meetings on other evenings in the week but Saturday, as so many men go down for the week end, and larger attendances may in this way be forthcoming.

During next week the old clothes basket will again be put out in the College Quadrangle. Last year they picked up of the fragments two baskets full, brimming over and pressed down, and these clothes have been very useful and much appreciated. We would suggest that old white ties and white kid gloves are not of much use to the suffering poor, but rather may lead to inordinate vanity among the uneducated. Old clothes of the ordinary domestic type are the most useful.

Papers by Guy's Men.

Alcoholic Insanity. By Dr. Savage.—*Clinical Journal*, August 30th.

The Practice of Blood-Letting. By J. F. Briscoe, M.R.C.S.—*Ibid.*, August 9th.

A simple method of Localizing by Rœntgen Rays. By E. W. H. Shenton.—*Archives of the Rœntgen Ray*, August.

Nursing Notes.

Autumn and Winter are essentially the seasons for classes, and though we are afraid the matter is a little outside our province, the time is ripe, we think, to venture to renew a suggestion that must have been made many times, but which never seems to have been put into practice. This is, that the students at a suitable period in their hospital career shall attend classes and receive instructions from sisters or head nurses appointed by the matron, or a committee, on the making of poultices, enemas, and a few nursing points, on which we venture to say the great majority of men are ignorant.

These classes would not be so much for their benefit in the hospital, that would not be desirable, as they would probably wish to have a report as to the manner in which every poultice was made, or enema given, but for use in private practice, where a trained nurse is not always procurable.

In an effort to administer oxygen we have seen one of our surgeons hopelessly wind himself up in a yard or so of tubing, disperse the oxygen in great gusts over the counterpane anywhere but near the patient, twist the tubing into kinks until it burst, and in despair hand it over to the nurse. We have known H.P.'s and H.S.'s majestically order turpentine enemas, and by a question display extraordinary ignorance concerning the constituents or its consistency.

In a surgical ward after a change of lady pupils.

H. S. to Jimmie.—"Well, Jimmie, and who put your fomentation on this morning?"

Jimmie.—"The new sarvint, sir!"

May we express a hope that members of the choral society will be more uniformly diligent in their attendance at practices this winter. If they would there might probably be less need for such a vigorous whipping in as the concert draws near, and do away with the necessity for a four nights' a week practice, which may mean nothing very much to day nurses, but very much indeed to the poor night nurses as well as causing a general disturbance for non-members.

"L'INCONNUE."

Guy's Hospital Clubs' Union.

THE FORMATION OF THE CLUBS' UNION, by the amalgamation of the various constituent institutions, took place in the summer of 1891. The objects of the amalgamation are to further the interests of the clubs and societies existing at the Hospital by their mutual support, and to simplify the collection of subscriptions. By the payment of an annual subscription, or of a composition fee (see Clubs' Union Blue Book, page 14), to the Clubs' Union, any student of the Hospital can obtain the privilege of membership of the constituent institutions.

THE GROUND OF THE CLUBS' UNION, which is under the control of the council, is situated close to Honor Oak Park station, on the London, Brighton and South Coast Railway, and to the Crofton Park station on the London, Chatham and Dover Railway. It is nine acres in extent, and is the headquarters of the Guy's Football, Cricket, Athletic and Lawn Tennis Clubs. Under such restrictions as are found necessary by the committees of the several clubs, and are approved by the council of the Clubs' Union, every member of the Union has opportunities of practising and taking part in matches, and in the various sports and games. There is a large pavilion upon the ground, with dressing and lavatory accommodation. Refreshments can be obtained by members of the Union according to the tariff of the Students' Club.

The ground-man, who is a professional cricketer, has quarters in the pavilion. His duties are to keep the ground in order, to prepare the wickets and lawn tennis courts, and to bowl to such members of the Union as shall be selected by the committee of the Cricket Club. Lockers may be rented on application to the ground-man, at a charge of 5s. for the summer or winter season, 2s. 6d. deposit is also required on the key.

Cheap railway tickets between London Bridge and Honor Oak Park stations are issued to members of the Union upon conditions which will be found enumerated in the Clubs' Union Blue Book.

THE HOSPITAL "BLUE."—The "Blues" Committee, consisting of two representatives from each associated club, award "Blues" and "Half-Blues" to members of the following teams:—Rugby Football, Association Football, Cricket, Athletic, Lawn Tennis, Water Polo and Bicycle, after considering the list of men suggested by the various Clubs' Committees through their delegates. Blues are awarded half-yearly, at the end of each session, so that the Rugby Football team be represented by fifteen Blues, the Association Football by eleven Blues, Cricket by eleven Blues. The Athletic by "Blues" and "Half-Blues," dependent on the recommendation of the Athletic Committee, according to the performances at the Inter-Hospital sports. The Lawn Tennis by three Blues and three Half-Blues, the Water Polo by seven Half-Blues, and the Bicycles by six Half-Blues.

CONSTITUENT INSTITUTIONS.

THE FOOTBALL CLUBS.—President, J. N. C. Davies-Colley, M.A., M.C., F.R.C.S. Rugby—Captain, R. C. Mullins; Hon. Sec., F. G. Gibson; Captain Second XV., M. A. Collins; Captain Third XV., R. D. Bridger; and a committee of five, one representing each year. Association—Captain, H. P. Wiltshire; Hon. Sec., W. M. Robson; Captain Second XI., D. G. Greenfield; and a committee of five, one representing each year.

The Rugby Football Club has now been in existence for over fifty years, the season of 1899-1900 being the fifty-sixth. Very little is known about its early history, it is, however, recorded that when the Rugby Union was formed in 1871, the G. H. F. C. was one of the original pioneers, and the only hospital club in the movement; it then had a reputation second to none. The club's position in the football world was acknowledged by the Union electing J. H. Ewart to serve on its first committee, which included such historic names as A. Rutter (president), E. H. Ash (hon. secretary), F. J. Currey, F. Stokes, and A. G. Guillemard. Amongst the many brilliant players who at one time or another have appeared for Guy's may be mentioned the following International footballers:—A. W. Pearson, W. W. Pinching, A. H. Jackson, L. Stokes (captain 1877–8), A. S. Taylor, W. G. Mitchell, H. W. Dudgeon, A. Allport (England); H. M. Jordan (Wales); R. Evans (Scotland); and F. O. Stoker (Ireland).

In 1874 the Inter-Hospital Challenge Cup was instituted, which Guy's were fortunate enough to secure for the first time. Since its institution, St. Thomas's have held the Cup ten times; Guy's six times; St. George's three times; London and St. Bartholomew's twice each; and Middlesex once.

In 1891, Guy's, Middlesex, and St. Thomas's were left in, the ties not being played out.

We hope that backs, as well as forwards, will make the best use of the very excellent opportunities there are at Honor Oak Park, and in the gymnasium, of getting and keeping fit.

For the first time on record there are complete lists of fixtures for Third and Fourth Fifteens, and the Committee trust that men will, by their presence, make it possible for the Club not only to fulfil its engagements, but to secure a list of victories that will redound to the credit of the Hospital.

A trial game will be held on October 4th, further notice of which will be posted on the notice-boards.

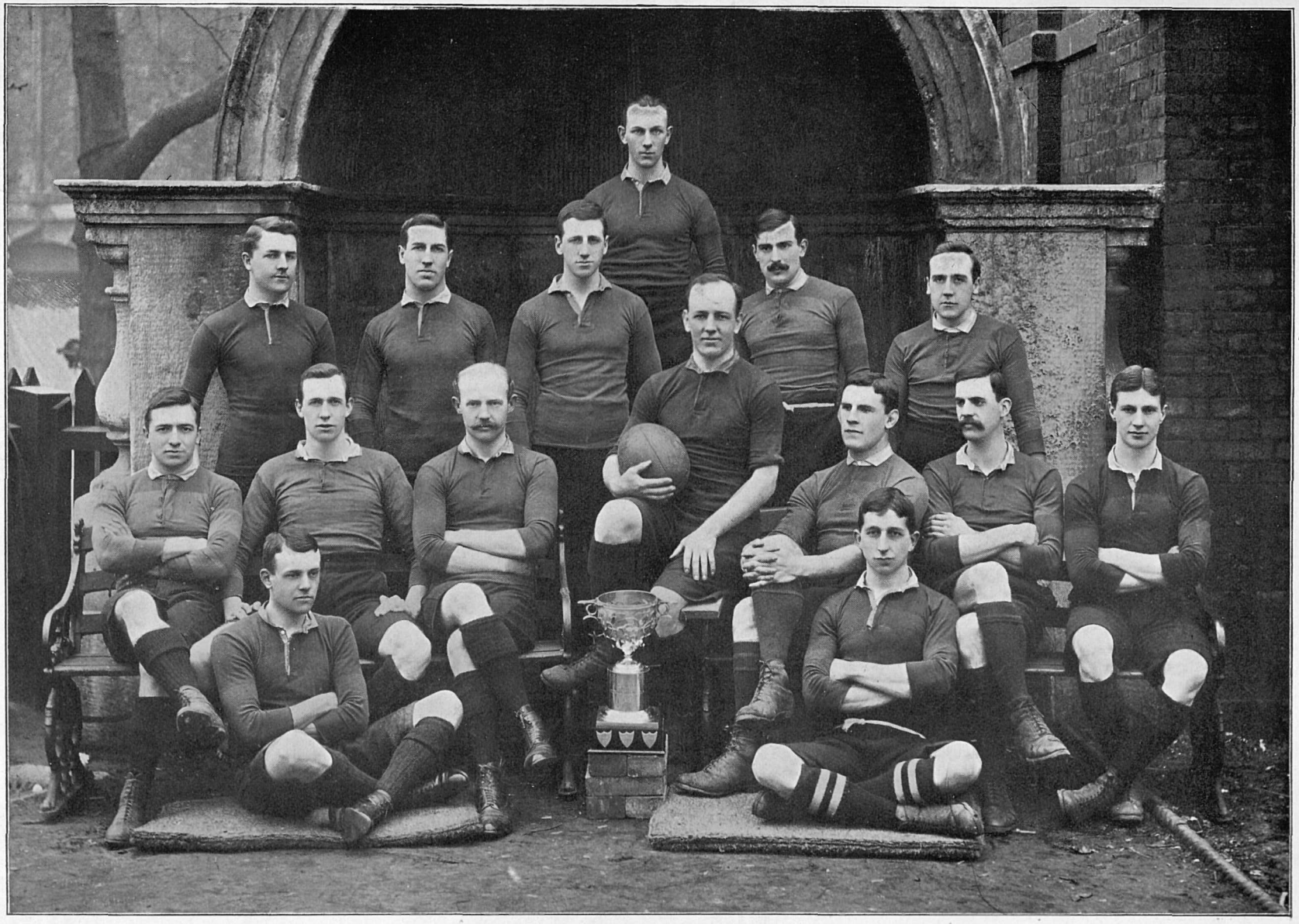
All freshmen wishing to take part in hospital football are particularly requested to try and make a point of playing in this game. The first match will be on October 7th with Kensington.

A ball for practice can always be obtained at the ground at Honor Oak Park.

The officers of the club will always be very glad to give any information required.

H. A. Cutler.

A. O'Brien. A H. E. Wall. K. V. Trubshaw. P. T. Manson. T. Hilton.



M. C. Wetherell. A. A. Smith. T. P. Thomas R. C. Mullins D. H. Trail. F. W. Sime. A. C. Ransford.
C. D. Pye-Smith (Hon. Sec.) (Capt.) F. D. S. Jackson.

Guy's Hospital First Rugby XV.—Winners of Inter-Hospital Senior Challenge Cup, 1898—99.

The following matches have been arranged for this season:—

FIRST FIFTEEN.

Oct.	4	Trial game	Home
	7	Kensington	Away
	14	Lennox	Home
	18	Cambridge	Away
	21	Old Leysians	Away
	28	*Cardiff	Away
	30	*Penarth	Away
Nov.	4	Rosslyn Park	Away
	11	Catford Bridge	Home
	15	Royal Engineers	Away
	18	Bedford	Away
	25	Old Merchant Taylors	Away
Dec.	2	Blackheath	Away
	9	Croydon	Away
1900			
Jan.	6	Old Leysians	Home
	13	Croydon	Home
	17	East Sheen	Home
	20	Rosslyn Park	Home
	27	Harlequins	Away
Feb.	3	Catford Bridge	Away
	10	Kensington	Home
	17	Lennox	Away
	24	R.I.E.C.	Away
Mar.	10	Richmond	Away
	17	London Irish	Away

*Combined with St. Thomas's Hospital.

SECOND FIFTEEN.

Oct.	7	Kensington	Home
	14	Lennox	Away
	18	Westminster Hospital	Home
	21	Old Alleynians	Home
	25	St. Thomas's Hospital	Away
	28	Beckenham	Away
Nov.	4	Rosslyn Park	Home
	11	London Irish	Away
	15	Westminster Hospital	Home
	18	Beckenham	Away
	25	Old Merchant Taylors	Home
Dec.	2	Polytechnic	Away
	9	Croydon	Home
	13	St. Bartholomew's Hospital	Away
	16	London Irish	Home
1900			
Jan.	6	Rosslyn Park	Away
	13	Croydon	Away
	17	St. Thomas's Hospital	Home
	20	Hammersmith	Away
	24	St. Bartholomew's Hospital	Home
	27	Streatham	Home
Feb.	3	Marlborough Nomads	Home
	10	Kensington	Away
	14	Merchant Taylors School	Home
	17	Lennox	Home
	24	R.I.E.C.	Home
Mar.	3	Streatham	Away
	10	Marlborough Nomads	Away

THIRD FIFTEEN.

Oct.	7	St. Paul's School 2nd XV.	Away
	14	Croydon III. (4 p.m.)	Away
	21	Surbiton A	Away
	28	Beckenham A	Home
Nov.	4	Tonbridge School 2nd XV.	Away
	11	Blackheath Proprietory School	Away
	18	Hammersmith A	Home
	25	Dulwich College 2nd XV.	Away
Dec.	9	Catford Bridge 2nd XV.	Away
	16	Hammersmith A	Away
Jan.	6		Away
	13	Polytechnic A	Away
	20	Beckenham A	Away
	27	Dulwich College 2nd XV.	Away
Feb.	3	Sidcup A	Away
	10	Catford Bridge 2nd XV.	Away
	17	Blackheath Proprietory School	Away
	24		Away
Mar.	3	Southwark A	Away
	10	Sidcup A	Away

FOURTH FIFTEEN.

Oct.	7	Park House C	Away
	14	Old Alleynians 3rd XV.	Away
	21	Mortlake St. Mary's	Away
	28	Catford Bridge 4th XV.	Away
Nov.	4	Lewisham A	Away
	11		Away
	18	St. Paul's School 3rd XV.	Away
	25	Wimbledon A	Away
Dec.	2	Streatham 4th XV.	Away
	6	Merchant Taylors School 3rd XV.	Home
	9	Maze Hill A	Away
	16	Mortlake St. Mary's	Away
Jan.	6	Streatham 4th XV.	Away
	13		Away
	20		Away
	27	King's College Engineers 2nd XV.	Away
Feb.	3	Catford Bridge 4th XV.	Away
	7	Dulwich College 3rd XV.	Away
	10	Wimbledon A	Away
	17	Epsom College 2nd XV.	Away
	21	Merchant Taylors School 3rd XV.	Away
	24	Lewisham A	Away
Mar.	3		Away
	10	Sidcup 3rd XV.	Away

F. G. GIBSON, Hon. Sec.

The Association Club has now been in existence for seventeen years, being instituted in 1882. Since that time it has, for the most part, been in a flourishing condition. For the first four years after the institution of the Inter-Hospital Challenge Cup (1886–89) Guy's obtained that trophy, and in two of these years, 1887 and 1889, won the Surrey County Cup as well. In 1894, the Inter-Hospital Cup was again won, and once more in

1897. Guy's have now held the Cup oftener than any other hospital, having won it six times out of a possible fourteen.

Amongst the prominent players who have represented Guy's in Association football may be mentioned H. J. Holman, H. B. Bolus, E. T. Mitchell, H. Hickman, N. C. Cooper, N. Lavers, A. M. Daniel, A. B. Carter, R. T. Fitz-Hugh, H. M. Barker, and L. Humphry.

This year Mandy will be missed as he is now out of his year. If, however, freshmen come forward as they are expected to do, we should find no difficulty in making up the team again.

There are three trial games this season, October 4th, 7th and 11th, so that all men should be able to play. Freshmen especially should turn out for these, otherwise their play may never be seen, and so their talent wasted. Lists will be posted in the colonnade and smoking-room for men to put down their names and the position they play in. We should urge on members of the team, who are unable to play in any match, the necessity of scratching their names off as soon as the list is put up, instead of waiting till the last moment.

The Cup must be brought back again this season if possible, and to do this the team must be settled as early in the season as possible and the same men play regularly. If this is done we have a good season before us.

The following matches have been arranged :—

FIRST ELEVEN.

Oct.	4	Trial game	Home
	7	Trial game	Home
	11	Trial game	Home
	14	Old Harrovians...	Home
	21	Godalming	Away
	28	...	
Nov.	1	Hastings	Away
	4	Reigate Priory	Away
	8	St. Leonards	Away
	11	Old Cranleighans	Home
	18	Ewell	Away
	25	Weybridge	Away
	29	Royal Veterinary College	Home
Dec.	2	...	
	9	...	
	16	Idlers	Home
1900			
Jan.	6	Weybridge	Away
	13	Reigate Priory	Away
	20	...	
	27	Beckenham	Home
	31	Royal Veterinary College	Away
Feb.	3	Ewell	Home
	7	R.M.A.	Away
	10	Old Eastbournians	Home
	17	...	
	24	Beckenham	Away
Mar.	3	...	
	10	...	
	17	...	

SECOND ELEVEN.

Oct.	4	Trial game	Home
	7	Trial game	Home
	11	Trial game	Home
	14	...	
	21	L.C.C.	Home
	25	R.M.A.	Away
	28	Eversleigh	Away
Nov.	4	Furzedown Park	Home
	11	Old Cranleighans 2nd XI.	Away
	18	Ewell 2nd XI.	Home
	25	Central Technical College	Home
Dec.	2	...	
	6	City of London School	Home
	9	Old Foresters 2nd XI....	Home
	16	Banstead	Away
1900			
Jan.	6	Kenley (reserve)	Home
	13	Old Cranleighans 2nd XI.	Home
	20	...	
	27	...	
Feb.	3	Ewell 2nd XI.	Away
	10	Furzedown Park	Away
	17	City of London School	Away
	21	Banstead	Home
	24	Beckenham 2nd XI.	Home
	28	...	
Mar.	3	...	
	10	Central Technical College	Away
	17	...	

THE CRICKET CLUB.—President, W. A. Brailey, Esq., M.D.; Captain, K. V. Trubshaw; Vice-Captain, J. M. Brydone; Hon. Sec., G. T. Willan; Captain second IX., H. R. Grellet; Vice-Captain, J. T. Hicks: and a committee of five.

Guy's have always done well at Cricket, and since the institution of the United Hospitals' Challenge Cup, in 1882, have held the coveted trophy for no fewer than eleven years, from 1884–88 inclusive—the Cup which is now the absolute property of the hospital, and used to decorate our smoking-room—from 1890–94, and in 1897.

In the first two years of the competition King's were successful, then for the following eleven years Guy's held the Cup with the exception of 1889, when St. Thomas's took it from us. Since 1894 our efforts have not been crowned with such remarkable success, but in 1897 the Cup again returned to Guy's after a most exciting match with University College, when we won by the small margin of two wickets. As may be imagined, with such success, we have by far the best results of any hospital. From 1886–98 we scored in Cup-ties alone 7663 runs to 5155 of our opponents. The highest individual scorer was J. C. Shenton with 172, and an average of 91 for cup-ties. Three-figure innings have also been secured by W. J. Scott, F. Colclough, J. H. Joyce, W. I. Hancock, C. E. Francis and F. C. Wetherell, who scored 135 this year v. St. Thomas's. In bowling every year there have been excellent performances. Among the most notable

were those of C. H. Rygate and J. D. Cruickshank, who bowled all the King's wickets down in 1886 for the cost of *three* runs; of J. H. Bettington who took seven wickets for twenty-one against Bart's., in 1890, as did W. G. Mitchell against St. Mary's in 1887; of J. H. Joyce in 1893, who captured twelve of the King's wickets for 36, and eight of Westminster's for 19 runs; of F. C. Wetherell in 1897, who took five University wickets for 15, and of A. E. Clarke in 1896, when v. Bickley Park he took nine for 43, and v. Brentwood eight for 16 runs. There are many names of note in connection with cricket at Guy's, to mention all of which would crowd out other matter. However, in addition to those mentioned are A. F. Clarke of Mitcham, E. J. D. Mitchell, S. Wacher, Edgar Reid, and the late J. B. Bettington.

THE ATHLETIC CLUB.—President: R. Clement Lucas, Esq., B.S., F.R.C.S. Hon. Secretaries and Treasurers, D. H. Trail, F. W. Sime; and a committee of ten.

The annual meeting of the Athletic Club is held in June at the Clubs' Union Ground, Honor Oak Park. From amongst the successful competitors, the team to do battle for Guy's at the United Hospitals' meeting is selected. Since the institution in 1867 of the Athletic Championship of the United Hospitals—the first inter-hospital competition of any kind—Guy's, who were the first to secure the shield, have won it on eight occasions, St. Bartholomew's ten times, St. Thomas's five times. King's, St. George's and St. Mary's thrice each, and London once. Amongst the prominent athletes who have performed for Guy's are, W. Maltby, who appeared for North v. South in the two miles during 1873; A. W. Pearson, J. Reader, J. G. Gravely (1877), hurdles, in which his record, 16¾ seconds, remained unbroken until the present year; L. Stokes, A. S. Taylor, W. G. Mitchell, H. A. Munro, who for five years (1891–95) won the mile and three miles, in each of which he holds hospital record, and in 1895 he won the amateur championship for four miles; H. T. S. Bell, who has three times (1892–94) won the 100 yards, twice (1892–93) each the 220 yards and high jump, and long jump (1893–94); in his last year he also tied for first place in the "high"; P. R. Lowe, hurdles (1892–93); F. S. Batchelor, 440 yards (1893); and E. N. Scott, throwing the hammer (1893–94–95).

It is to be hoped that the Cross Country Club will find some fresh talent among the men now entering, as it would be a great pity to lose the Cup which we have now held for so long. The headquarters are at the Royal Forest Hotel, Chingford, on the borders of Epping Forest, from which some most delightful tracts of country are easily accessible. Short runs also take place during the week from our ground at Honor Oak Park. The Club especially appeals to those men who have just come up from the country and will feel the need of exercise, in town, most keenly, and above all to those who do not intend to play in any of the "footer" teams. Guy's have now held the Inter-Hospital Cross Country Challenge Cup for eight years running.

The opening run will be on the first Saturday in October. Slow and fast packs will be started, and only a moderate run attempted. Matches have been arranged against various other clubs, and there will be a Novices' Prize race on the second Saturday of the season. Fixture cards will be out in October. All information can be obtained from R. S. Roper and S. J. Ormond. Train: 2·32 p.m. from Liverpool Street.

THE LAWN TENNIS CLUB.—President: W. Arbuthnot Lane, M.S., F.R.C.S. Vice-President: J. W. Washbourn, M.D. Captain: P. S. Mandy. Hon. Secretary and Treasurer: H. K. Lacey; and a committee of eight. The club has been in existence some eight years. There are twelve very good grass courts at Honor Oak, which are open for play from the end of April to the end of September. The club holds, at the beginning of the season, several trial games, which serve to bring before the notice of the committee all promising new players, while one or two matches are played weekly against various London clubs. The Inter-Hospital Challenge Cup was instituted in Jubilee year; it was held by St. George's until 1890; Guy's held it in 1891–1892; St. Thomas's, 1893–1896; St. Bartholomew's, 1897; London, 1898, and this year it was won by St. Bartholomew's.

THE RIFLE ASSOCIATION.—President: L. A. Dunn, M.S., F.R.C.S. Captain: B. W. Moss (Artists R.V.) *Hon. Secretary and Treasurer: Stanley Hodgson* (Artists R.V.); and a committee of five.

The Association arranges matches with the sister hospitals of London and with public school cadet corps, and also enters a team to compete for the United Hospitals Challenge Cup (held by Guy's in 1898) at Bisley during the "week." In the former series both Civilians and Volunteers are eligible to represent the hospital, but in the latter the regulations of the N.R.A. preclude any save Volunteers from competing. For this reason all new men who wish either to continue or to commence rifle shooting are requested to communicate immediately with the hon. sec. of the Association, who will give them information with regard to suitable volunteer corps.

The Annual Prize Meeting and Newton Pitt Challenge Cup Competition will be held early in October. The exact date will be posted on the notice-board in the Colonnade.

THE BICYCLE CLUB.—President: C. H. Golding-Bird, F.R.C.S. Captain: J. E. L. Bates. Vice-Captain: A. M. Gabriel. Hon. Secretary and Treasurer: Hugh T. Campkin; and a Committee of six.

The Club meets for runs every Saturday, except when engaged in race meetings, of which there are four every year, in addition to hospital contests.

A general meeting for the election of officers, etc., will take place in November, and all students who are cyclists are requested to communicate with the Hon.

Secretary, or any member of the committee, and thus obtain full particulars.

The object of the club is to promote social runs among the members. In addition to several valuable prizes for competition, the President has given a very valuable cup to be raced for annually by members, the winner holding the championship for the season. The Captain is the present champion. It is hoped that all speed men will make themselves known, so as to be of service during the coming season.

The hospital has been represented in the United Hospitals, Cambridge, Oxford, London B.C., and Sheen House matches, and this year has won the Challenge Shield for the fifth time in succession.

GUY'S HOSPITAL SWIMMING CLUB.—WATER POLO.—President: A. D. Fripp, M.S. Vice-Presidents: L. A. Dunn, M.S., J. Fawcett, M.D., W. R. Wood, L.D.S., M.R.C.S. Captains: D. G. Greenfield (1st team). Vice-Captain: D. H. Trail. (2nd team) R. Franklin. Committee: A. H. Smith, J. H. Wilkes, H. N. Grose, G. Evans, J. L. Payne. Hon. Secretary and Treasurer: A. C. Edwards.

The Swimming Club this past season has not distinguished itself as it might have done had it not lost some of its best members. Several new men joined and there is a bright look out for next year if they continue practising regularly.

In the friendly games we were very unfortunate, several matches having to be scratched at the last moment from men being unable to play.

The Club entered for the Surrey County Water Polo Competition, and beat St. Thomas's by two goals to one, (Wilkes and Franklin). We were beaten in the inter-hospital team race by Bart.'s by about ten yards. There is an opening for good swimmers to distinguish themselves. We can win the cup if we only try, as there are plenty of very fair men; but the only thing is practice. Our team consisted of Dignum, Greenfield, Reinholt, and Edwards.

In the Inter-Hospital Water Polo Cup Ties we beat London Hospital by one goal to none, the goal being scored by our Captain.

The final was played at the Bath Club, through the kindness of our President, A. D. Fripp, Esq., M.S. Bart.'s started by scoring a goal, but we quickly retaliated by Edwards scoring one for Guy's. The game was rather rough as several Bart.'s men had a very vague idea about fair play and were constantly using their feet. Ash had a chance to score another goal, but somehow he missed it. The result was that Bart.'s won by two goals to one. H. N. Grose played a splendid game, as did also our goal-keeper, Wilkes, who saved some very fine shots.

It seems a pity that full blues are not given for water polo, as the sport is as deserving as any other. For instance, if two full blues were given a year and the rest half blues, it would add any amount of interest and keenness to the game, and the hospital would again come to the front as it did a few years ago, when full blues were awarded.

The Club is indebted to Mr. Baker, the Superintendent of the Baths, for his kindness and courtesy to all members.

THE PUPILS' PHYSICAL SOCIETY.—Hon. President: Sir Samuel Wilks, Bart., M.D., LL.D., F.R.S. Hon. Secretaries: G. Bellingham Smith, B.S., and A. P. Beddard, M.D.

This flourishing Society was founded in 1830, on the plan of the old Physical Society, which existed during the latter part of the eighteenth century at Guy's Hospital. From a copy of the old laws of the Physical Society, dated 1800, we learn that the Society met every Saturday night, from seven to ten, during the month of October, and each month until the following May. Business at these meetings was divided into private, including "matters in which the Society may be concerned," and public, consisting "in the communication of cases and opinions." A fine of sixpence was exacted from a member absent at the "Roll Calls," also from a member refusing "to hold up his hand on one side or the other," to decide any question. Members were divided into honorary, ordinary and corresponding. So much for the old Physical Society, of which an account is given in the *Biographical History of Guy's Hospital*, by Bettany and Wilks, a work which every Guy's man should possess. It may be obtained from the librarian, who has still some copies of the first edition, price 10s. 6d.

At the Pupils' Physical Society, which meets fortnightly on Saturday evenings, a paper on some subject, not necessarily of medical interest, may be read by any member, to be followed by a discussion.

"Clinical and Pathological Evenings" are devoted to the exhibition and discussion of interesting cases or specimens which may be shown by any member.

On October 2nd, 1899, there will be a general meeting of the Society after the house dinner. Sir Samuel Wilks, Bart., F.R.S., will take the chair, and Dr. Wheelton Hind will read a paper on "Geology as a Hobby."

Members are reminded that in connection with the Society the following prizes are offered for competition:—The Treasurer's Prize of £5 is given annually, and the subject of the Essay for the ensuing session is "The Surgical Treatment of Gastric Ulcer." The Society offers a prize of £10 for the best paper read during the session; a prize of £5 to the member who distinguishes himself most in the discussions; and a prize of £5 to the member who exhibits the best specimens of scientific interest during the session (see Clubs' Union Blue Book, page 53).

THE DENTAL SOCIETY.—President: A. E. Baker, M.R.C.S., L.R.C.P., L.D.S. Vice-Presidents: J. F. W. Silk, M.D.; E. B. Dowsett, L.R.C.P., M.R.C.S., L.D.S.; J. W. Pare, M.D., C.M., L.D.S.; J. L. Payne, L.D.S.

Hon. Secretary and Treasurer: S. L. Prall. Committee: P. H. Hayes Palmer, L.D.S., J. H. Wilkes, C. W. Corfe, G. H. Morris.

The Society was founded in the early part of 1894. Its fifth session commenced in October last, and was eminently successful in every way; good papers were read and much interest was taken in the meetings by the members.

Meetings are held every month during the winter session. They are held in the Dental Lecture-room, on the second Tuesday in each month, at 4.30 p.m. Papers on subjects of dental interest are read, after which a discussion takes place; clinical cases are also shown at each meeting; and one evening during the session is specially set apart as a clinical evening. This year a prize of £5 will be given for the best paper read before the society. The first meeting will take place on October 10th, at 4.30 p.m.

THE GUY'S HOSPITAL CHRISTIAN UNION (Hon. Secretaries: C. S. Morris, P. R. Bolus, D. W. Smith) has for its object the furtherance of the Christian life at Guy's Hospital. It is the perpetuation of the meetings instituted here by Drs. Habershon and Golding-Bird over forty years ago. On Thursdays, at 5 p.m., addresses are given by visitors invited for the occasion. These meetings are held in the board-room by the kind permission of the Treasurer. A room (No. 43) in the College is rented by the members for committee meetings, prayer meetings (daily at 1.10 p.m.), tea and social intercourse. The Missionary Society, which is strictly undenominational, is doing good and useful work. The attempt thus made to unite the interest of the students in the work which is being carried on in foreign lands by medical missionaries, and to increase the knowledge of missionary work, has proved to many a source of helpfulness.

The opening meeting of the Union will take the form of a conversazione, to which all members and freshmen are invited, and will be held at 5 p.m., on Thursday, October 5th, in the board-room, on which occasion Dr. Pye-Smith hopes to preside. On October 19th the annual sermon will be preached in the chapel of the hospital at 4.30 p.m. On each preceding occasion there has been a large attendance, and it is hoped this year will see a large congregation.

The list of meetings for the ensuing quarter will be published shortly. Copies may then be obtained in room No. 43 in the college or from the secretaries.

THE DEBATING SOCIETY.—President: F. W. Pavy, M.D., LL.D., F.R.S. Vice-Presidents: L. A. Dunn, M.S., F. G. Hopkins, M.B., B.Sc., and J. Fawcett, M.D. Secretaries and Treasurers: F. Shufflebotham, S. J. Ormond; a committee of six students.

The Debating Society is entering on its seventh year of existence, and its fourth as a constituent of the Clubs' Union. Meetings are held once a month on Saturday night in the Club smoking-room, when debates take place on some subject of political, scientific, literary, or of general interest. The discussion of theological questions is prohibited.

At the end of the session there is a "Ladies' Night," which is largely patronized by the Staff and their families, the Sisters and the Students of the London School of Medicine for Women. During the summer season there are no ordinary meetings, but there is an annual dinner, which is followed by an impromptu debate. The first meeting will probably take place on October 22nd.

All members of the Clubs' Union are requested to support the Society by attending the meetings, and if possible to take part in the debates, though no one will be called upon to speak against his wish.

Members who are willing to bring forward subjects for debate are requested to communicate with one of the secretaries.

THE GUY'S HOSPITAL GAZETTE is published fortnightly on Saturdays, from the library of the hospital, where copies may be obtained by all members of the Clubs' Union and by immediate subscribers to the GAZETTE. The first number was published on October 1st, 1872, and the GAZETTE is thus entering on its twenty-eighth year of existence. It was the first medical students' journal ever published in this country. It ran an uninterrupted course until 1879—the last number appearing in November of that year—or, for that matter, in any other, so far as can be ascertained, and was then suppressed, rather from excess of zeal than from lack of material. The present "new series" was inaugurated in 1887, and since that time it has continued to flourish without a break. The original GAZETTE was a two-leaf publication and only had a small circulation in the hospital itself. Its circulation now practically includes all Guy's men throughout the world, as well as the Nursing Staff past and present. This prosperity, as few men realise, depends largely upon the sound financial footing on which it is placed, and upon the business-like arrangements for its publication which are mainly due to the business staff of the hospital and medical school.

The columns of the GAZETTE are open to any reasonable correspondence concerning grievances, improvements, or facts of interest, the writer's name being requisite as a guarantee of good faith, if not for publication. All contributions must be deposited in the editor's box in the colonnade, or addressed to the editor by post by Wednesday at latest in each week of issue.

THE REPORTS.—Edited by W. H. A. Jacobson, M.A., M.Ch., and E. C. Perry, M.A., M.D.

The first volume of the Guy's Hospital Reports appeared in 1836. The Reports are now published annually, and contain contributions upon professional and scientific subjects from the staff of the Hospital and Medical School. The volume of the present year is the 54th.

THE STUDENTS' CLUB.—Committee till 1900 (March). President: P. H. Pye Smith, M.D., F.R.S. Treasurer: C. J. Symonds, M.S. Hon. Secretary: J. Fawcett, M.D. Hon. Assistant Secretary: F. G. Cross. Committee: G. B. Smith, B.S., F. J. Steward, M.S., F. G. Cross, W. S. Handley, F. G. Gibson, H. V. Bagshawe, T. P. Thomas, and the President of the Residents.

The above-named manage the affairs of the Club, a full account of which will be found in the Clubs' Union Blue Book, p. 63.

GYMNASIUM.

The Pavy Gymnasium, which was built and furnished by the liberality of Dr. Pavy, is open daily for practice, and during the winter session a boxing instructor attends on each Thursday afternoon, and a gymnastic and fencing instructor on each Tuesday afternoon. At the end of the session a competition for prizes is held, and a display of gymnastics and boxing and fencing is given on the "Ladies' Night."

The course of boxing for the season 1899-1900 will start with a lesson on Thursday, October 6th, while the first class in fencing and gymnastics will meet on the following Tuesday. Staff-Sergeant Young, who has for many years given entire satisfaction for his civility and efficiency as instructor in gymnastics and fencing, will this season teach the art of boxing as well, so that it is hoped by the committee that Guy's men, more especially new men, who have an all-too-short five years before them, will do their best to again bring Guy's to the front as champion hospital in the boxing competitions; and the committee also hope that sufficient new blood will be introduced this October to keep up the high standard of the annual assault-at-arms.

Clubs' Union Report & Balance Sheet.

THE Council of the Clubs' Union have much pleasure in presenting the Seventh Annual Report of the progress of the Union, together with a statement of the Receipts and Expenditure since April 1st, 1898.

The total number of members on March 31st, 1899, was 1,953, of whom 1,720 are life members, 200 annual subscribers, and 33 patrons; an increase of 72 since the issue of the last report.

The continued support accorded by the Governors and Consulting and Acting Staff, and old Guy's men, is most gratifying to the Council. We again venture to point out to old Guy's men who have not paid their life subscription of one guinea, the advantages of having their names and addresses in the Clubs' Union Blue Book, which is a useful directory and is much used by members who wish their patients when away from home to be looked after by Guy's men.

During the winter months, Harris, the ground man, has shifted the road at the Brockley end of the ground about six yards nearer to the fence, and by this means the ground has been much improved, and also increased in size for playing purposes. This will be a great boon to the Association Football Club, who will be able now to have a full-sized ground, and to play cup-ties at home. It will also enable the Tennis Club to increase the number of their courts. In the autumn a number of lime trees were planted round the ground, and in a few years will form a pleasant and effective screen, which will be much needed on account of the number of houses which are being built in the neighbourhood.

The agreements with the St. German's Cricket Club, and Travers & Sons' Cricket Club have been renewed. Permission has again been granted to the members of the Guy's Hospital and School Servants' Cricket Club to practice cricket on two evenings in each week during the season.

The Athletic Club held their Annual Meeting on the Clubs' Union Ground on June 22nd, 1898, and the meeting will again be held there this year, in the month of June, the exact date to be announced in a later issue of the GAZETTE.

The best thanks of the Council are due to the officers of the Constituent Institutions, to the Auditors, and to Mr. Croucher and the other members of the School Office Staff for their able assistance.

The income for the year was £2,103 11s. 9d., the expenditure £1,610 11s. 9d., leaving a balance of £493. This large balance is partly due to the fact that three of the Constituent Institutions did not apply for their grants until after the end of the financial year

Statement of Receipts and Expenditure from 1st April, 1898, to March 31st, 1899.

1898. RECEIPTS.	£ s. d.	£ s. d.
April 1st.		
To Balance at Bankers ...	217 15 7	
„ Petty Cash balance in hand	4 4 11	
		222 0 6
Aug. 31st.		
To Subscriptions and Donations from April 1st to August 31st, 1898	308 5 6	
1899.		
March 31st.		
To Subscriptions and Donations from September 1st, 1898, to March 31st, 1899 ...	1192 15 6	
		1501 1 0
„ Grant from Medical School for 1898 ..		100 0 0
„ Grant from Dental School, for 1898 ...		15 0 0
„ Rent from Tenants		90 0 0
„ Rent from Lockers		12 13 0
„ Gate Receipts		16 7 6
„ Blue Book Advertisements		73 4 6
„ Sale of Railway Tickets		66 13 4
„ Deposit Interest		6 11 11
		£2,103 11 9

1899. March 31st.	Expenditure.	£	s.	d.	£	s.	d.
By Grants to Constituent Institutions—							
	Athletic Club	38	7	0			
	Bicycle Club	5	13	1			
	Christian Union	9	0	0			
	Cricket Club	17	6	2			
	Debating Society	8	7	4			
	Dental Society	9	12	4			
	Football Club, Association	14	8	10			
	Guy's Hospital Gazette ...	319	15	0			
	Guy's Hospital Reports ...	209	5	0			
	Rifle Association	12	3	0			
	Students' Club	246	1	7			
	Swimming Club	3	13	4			
	Tennis Club	16	9	4			
					910	2	0
„	Field current expenses ...	212	10	10			
„	Field Rent Account (Interest on Loans)	234	10	0			
					447	0	10
„	Management Expenses—						
	Printing and Stationery ...	5	16	8			
	Secretarial Expenses ...	47	0	9			
	Postage	4	9	0			
	Insurance	1	7	0			
	Production of Year Book ...	85	7	7			
					144	1	0
„	Railway Ticket Deposit Account ...				66	13	4
„	Rates and Taxes				40	13	5
„	Petty Cash Expenditure				2	1	2
„	Balance at Bankers ...	490	16	3			
„	Balance of Petty Cash in hand	2	3	9			
					493	0	0
					£2,103	11	9

J. W. WASHBOURN, Treasurer.
J. H. BRYANT, Hon. Sec.

Audited and found correct,
THOS. G. STEVENS.
May 15th, 1899. HERBERT L. EASON.

Guy's Hospital "Blue."

The following "Blues" and "Half-Blues" have been awarded.

"BLUES."

Retrospective-Cricket.—G. W. B. Featherstone.

Cricket.—E. G. Graham-Smith, H. M. Langdale, R. C. Poyser, H. R. Grellet, S. C. Bowle, E. W. Strange.

"HALF-BLUES."

Athletics.—F. E. Fremantle, F. J. Robinson, R. S. Roper.

Bicycle Club.—R. G. May, J. E. L. Bates, A. M. Gabriel, J. H. Greenwood, J. Black.

In Lighter Vein.

They tell me this is the Students' Number of the Gazette. I hope the Staff will forgive me if I "play it down a little"; for this occasion only I am writing for the Students.

I remember the days when I first came up to Guy's—I have a tenacious memory. I came chiefly on the recommendation of a Bart.'s man; I did not suspect his motives at the time or there might have been trouble. However, he's in practice now, and I would not kick a fallen foe.

In those days Mr. Wells used to sit in the Medical School Office, and I had an idea that he and the janitor were the boss men in the place. With a fearful shudder I heard him explain to my father that the office blinds were perforated and that, unseen himself, he could see every student who passed, who his friends were, what lectures he attended, and how he employed his leisure hours. Every day, from the time I got out of the train at London Bridge in the morning, till the time I re-entered it at night, I felt the eagle eye of Wells upon me.

One day when I found myself humming—

"My name is John Wellington Wells,
I'm a dealer in magic and spells,"

I felt that I had committed blasphemy.

And then the Janitor! Surely, I thought, he holds the keys of heaven and hell. As Mr. Wells was showing me round, we passed him; he had his back turned at the time, and he was deep in conversation with a friend. "You see that man," said Mr. Wells, "he's the Janitor. He knows everyone. He will never ask you your name; he knows it already. It is enough for him that you have looked at him." I thought this must be an even more marvellous man than Mr. Wells himself, and I felt that he could read my every thought and search me through and through even unto the scars on my liver.

It was not till I heard him sing "The Holy City" at a smoking concert that I realized that he was just the mere human man who wrote your name down when you attended a lecture and scratched it out again if he saw you sneaking out.

In those days I thought every "chronic" was a house-surgeon, and hoped I might one day be in his shoes. (The person who made that last remark is no gentleman). For at least three months I was too timid to take my modest lunch in the College, and would go quietly out to the A.B.C. shop and eat unobserved. Even now I sometimes fight shy of the College fare, but my motives are a little different.

I was a little surprised and more than a little amused to read the *Lancet's* opening address to new medical students The writer of the article states that "in the list of students now about to enter upon their chosen life-work at the several medical schools the progeny of wealth and lineage is, we may feel assured, conspicuous by his absence." The "fortunately born young men" are, he says, to be met with "in the Church, at the Bar, as civil engineers, on the Stock Exchange, in solicitors' offices, as journalists, and in trades of all sorts, but almost never in medicine."

"The modern medical man, while he inculcates cleanliness, should himself be clean beyond reproach—literally *homo factus ad unguem*."

"The medical man of the present day and near future . . . must resolve to live with prudence and circumspection, that he may prove to society that he is worthy of its regard."

Brethren, these are the words of the *Lancet*, the great organ of the medical profession, and shall we lightly disregard them? No! a thousand times no! Let us walk circumspectly though we burst. Let us take to wearing shirts, and let us give up spitting on the drawing-room carpet and eating peas with a knife. Let us stifle the fact that we are merely the sons of doctors, lawyers, stock brokers, and churchwardens, that ere we die we may prove ourselves worthy of the regard of Tod Sloan and Earl de la Warr, and that our declining years may be cheered by the sight of a son of our own being made a gentleman in a solicitor's office.

Dr. Perry has received a letter from a gentleman who wants to know "whether there is any cure for copperas in the nose." He adds that he has suffered from it for three years and finds it extremely trying. For once Dr. Perry finds himself beaten. The poor sufferer had better write to *The Echo*, there is a tame "doctor" on the staff of that paper who is never at a loss for a diagnosis or a remedy. A.

Reviews.

Hygiene and Public Health. By B. A. Whitelegge, M.D., etc., pp. 588. Price 7s. 6d. (Cassell & Co., 1899).

This work has now reached the seventh edition, and in this last edition are many additions which the progress of the science has rendered necessary. It is of course impossible for anyone to be an authority upon every subject in connection with public health, and we think that the book—valuable as it is—would be still more valuable if the 20 odd pages devoted to the Chemical Analysis of Water were eliminated. The account therein is not sufficiently detailed for a beginner, and as the subject is not fully dealt with, may convey erroneous impressions. This we maintain is the case with the table on p. 102. The interpretation of a chemical analysis of water is a subject teeming with difficulties and dangers, and to be dismissed with such a table is to our minds worse than useless. On the other hand, the digest of the Sanitary Law is most excellent, in fact, in our opinion, the clearest and most concise that exists.

Vital Statistics. By A. Newsholme, M.D., etc., pp. 353. Price 7s. 6d. net. (Swan Sonnenschein & Co., 1899).

This, the third edition, has been practically re-written. It seemed almost impossible to improve the second edition, but Dr. Newsholme has done it. As his work on Vital Statistics is used both wholesale and retail by practically every modern writer on the subject, it can easily be taken for granted that it fills a gap. It is a book that should be in the hands of every sanitarian.

Manual of Bacteriology. By Robert Muir, M.D., etc. and James Ritchie, M.D., etc. 2nd edition, 1899, pp. 564. Price 12s.

This well-known manual has in two years reached a second edition, which is not a mere reprint of the first edition, but has been brought up to date. As a manual of pathological bacteriology it is, we venture to say, without equal, and should be in the hands of everyone who is studying that subject. One thing has disappointed us, the authors in recommending a microscope only mention one, and that by a German manufacturer; whatever may have been said years ago, there is no doubt that at the present moment our English makers are not behind their German competitors as regards good and cheap microscopes. P.

From the Gazette's Special Pathologist.

NOTICES.

H. L., MANCHESTER.—Sections of this specimen show an abundance of grey tubercles infiltrating the muscular tissue of the scalp. The giant cell systems are well developed, and in several there is early caseation.

PATHOLOGIST.

Sport.

To the Editor of the GUY'S HOSPITAL GAZETTE.

DEAR SIR.—I believe it has now become the annual custom for the captain of the Rugby team to write a few words of welcome to those men entering Guy's each October, and it is with pleasure that I hasten to fulfil my duty and congratulate them on their choice of a hospital, a choice which I am sure they should have no cause to regret. For their information may I state that there are now four fifteens playing regularly each Saturday, with occasional Wednesday games, so that all men who wish, have a good chance of participating in the premier winter game. A notice will always be found posted in the colonnade and smoking room when a practice game is to be played, and it will much facilitate matters if intending players will subscribe their names early. I need hardly remind them that last season again saw Guy's successful in the Inter-Hospital Ties. All that is wanted to repeat that performance is a few keen men to fill the places of those no longer eligible. On behalf of the four captains, I should like to make one appeal, and that is that any man selected to play, has a really valid excuse before scratching off his name, and moreover, that in that event he lets the captain know of his intention as soon as he possibly can. Finally, it would be the best plan for all freshers who intend playing football, to let either the secretary or myself know early so that we may get in touch with them at once.—Yours etc.,

R. C. MULLINS.

Cricket

The Cricket at Guy's during the last season has not been so successful as in former years. Out of 18 matches played, 5 have been won, 10 lost, and 3 drawn. In the first place we were unfortunate in losing the services of seven of last year's team. The batting has been rather better than usual—if the averages can be taken as a fair criterion—Langdale gains the trophy with an average of 35·7 for 16 innings.

The bowling, on the other hand, has been very weak throughout. One of the chief difficulties we have had to contend with has been in inducing certain men to play, whose zeal for work apparently would not allow them to sacrifice three hours a week in helping their Hospital. We were just beaten by Thomas's in the second round of the Cup-ties in spite of a century by F. C. Wetherell.

BATTING AVERAGES 1ST XI.

	No. of Innings.	Times not out.	Total Runs.	Highest Score.	Average.
F. C. Wetherell	7	1	221	135	36·8
H. M. Langdale	16	3	465	102*	35·7
G. S. Graham-Smith	19	1	410	110	22·7
J. M. Brydone	9	0	196	101	21·7
R. C. Poyser	18	0	374	65	20·7
G. T. Willan	16	0	331	55	20·6
S. C. Bowle	18	2	289	67	18·06
K. V. Trubshaw	20	1	282	38*	14·8
H. R. Grellet	17	1	201	64*	12·5
C. M. L. Cowper	14	4	112	20	11·2
E. W. Strange	13	6	64	15	9·1

* Not out.

BOWLING AVERAGES.

	Wickets.	Average.
R. C. Poyser	13	15·5
K. V. Trubshaw	27	23·8
E. W. Strange	18	24·5
F. C. Wetherell	9	25·3
G. S. Graham-Smith	10	25·5
S. C. Bowle	15	34·5
C. M. L. Cowper	14	36

Appointments.

HOUSE APPOINTMENTS.

October, 1899.

The following appointments have been made by the House Committee upon the recommendation of the Medical Committee:—

House-Physicians.—Messrs. L. E. C. Handson (Dr. Hale White); W. H. M. Telling (Dr. Perry).

Assistant House-Physicians.—Messrs. A. H. Carter and H. L. Eason.

House-Surgeons.—Messrs. F. D. Turner (Mr. Howse); W. L. Baker (Mr. Davies-Colley).

Assistant House-Surgeons.—Messrs. G. S. Simpson, H. E. C. Fox (in the Surgery): J. G. Taylor (Mr. Jacobson); A. A. Miller (Mr. Symonds); A. R. Thomas (Mr. Lane); J. T. Dunston (Mr. Dunn).

Obstetric Residents.—Messrs. H. W. Bruce (October 1st); A. H. M. Saward (November 16th).

MEDICAL SCHOOL APPOINTMENTS.

October, 1899.

The following appointments have been made by the Medical Council and approved by the House Committee:—

Clinical Assistants.—Messrs. W. B. Secretan, E. Cohen, H. A. Gaitskell, J. F. Northcott, L. Wilkin, R. C. Mullins.

Clinical Assistant in the Aural Department.—Mr. C. H. Fagge.

Clinical Assistants in the Medical Out-Patients.—Messrs. J. M. Brydone (Dr. Shaw); H. B. Dismorr (Dr. Washbourn): E. H. Felton (Dr. Bryant).

Clerks in the Eye Wards.—Messrs. C. B. Penny, H. T. Palmer (October 1st); E. G. Andrew (November 16th).

Dressers in the Throat Department.—Messrs. C. R. Hodgson, H. J. Starling, O. Marriott, E. E. Parrett, H. R. H. Denny, C. E. Hicks.

Obstetric Dressers Messrs. F. O. Stoehr, J. S. S. Perkins (October 1st); F. A. Segreda (November 16th).

Assistant Surgeons' Dressers.—Messrs. H. S. French, E. F. G. Heap, E. H. Kitchin, F. B. Manser, R. D. Smedley (Mr. Jacobson); D. R. T. Griffiths, J. E. Collins, W. O. Roberts, S. S. H. Shannon, R. Thompson (Mr. Symonds); H. D. Kempthorne, V. M. Wallis, L. Hirsch (Mr. Lane); H. A. Ehrlich, L. E. Stamm, E. I. Claxton, G. G. Davidson, C. R. Howard (Mr. Dunn).

Medical Ward Clerks.—Messrs. G. T. Collins, F. Curtis, G. Evans, C. E. Gaitskell, F. D. S. Jackson, M. J. Rees, A. W. Soper, D. H. Trail, S. C. H. Bent, J. F. Douse, J. Evans, A. W. Gater, G. S. C. Hayes, W. M. Robson, A. Wylie, E. J. Crew, H. J. Gater, L. J. Hughes, G. H. H. Manfield, F. C. Wetherell, G. T. Wrench, H. W. Brown, M. A. Collins, W. J. Davies, A. C. H. Gray, G. W. C. Hollist, C. Tessier, E. Bigg, H. A. Cutler, R. C. Lawry, H. P. Wiltshire, J. A. Andrews, S. Child, E. G. Allport, O. W. Richards.

Surgical Ward Clerks.—Messrs. C. H. Gask, D. S. Graves, G. B. F. Churchill, W. A. G. Stevens, J. C. Curtis, T. G. Miles, M. Coplans, G. Moir, A. H. Turner, A. H. E. Wall, M. W. Cohen, R. T. Collins, J. W. Grommitt, G. E. Humphreys, W. G. Parker, R. Willan, H. Barber, F. H. Parker, J. C. O. Bradbury.

Assistant Physicians' Clerks.—Messrs. A. C. Nash, E. Roberts (Dr. Shaw); F. A. Beattie, H. C. Keates (Dr. Washbourn); A. Croneen (Dr. Bryant).

Clerks in the Skin Department.—Messrs. H. Braund, W. H. Brailey, T. E. Holmes.

Post-mortem Clerks.—Messrs. H. K. Lacey, R. D. Attwood (October-November); T. B. Fawley (November-December).

Dental Surgeon's Dressers.—Messrs. B. W. Moss (October-November); C. H. Brangwin (November-December); H. Braund (December-January).

Assistant Surgeons' Clerks.—M. F. L. Thomas (Mr. Jacobson).

Assistant Demonstrators of Microscopical Pathology.—Messrs. J. A. Butler, F. G. Cross, F. G. Gibson, R. S. Roper.

CIVIL.

BRODRICK, C. CUMBERLAND, L.R.C.P., L.R.C.S., L.M. Edin., has been re-appointed Medical Officer of Health for Tavistock, Devon.

BUCK, THOMAS ALPHEUS, M.B. Lond., has been appointed Admiralty Surgeon and Agent at Ryde, Fishbourne, and Seaview.

COLEMAN, M. O., M.D. Aberd., M.R.C.S., D.P.H. Eng., has been re-appointed Medical Officer of Health by the Surbiton Urban District Council.

DU BUISSON, E. W., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer to the Dewchurch District of the Hereford Union, *vice* R. Thomason, M.R.C.S. Eng., L.S.A., resigned.

HARDING, CHARLES A., L.R.C.P. Lond., M.R.C.S., has been re-appointed Medical Officer of Health by the Whittlesea Urban District Council.

KENDALL, B. C., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer for the Parish of Wendron, in the Helston Union.

KINSEY-MORGAN, A., L.R.C.P. Lond., M.R.C.S., has been appointed House-Surgeon to the Victoria Hospital, Bournemouth.

MUNCASTER, J. H., B.A. Camb., M.B. Lond., has been appointed Medical Officer for the North and North-owan Wards of the Halifax Union.

WALLIS, P. E., L.R.C.P. Edin., M.R.C.S. Eng., has been re-appointed Medical Officer of Health to the East Grinstead Urban District Council.

NAVAL AND MILITARY.

SURGEON NORMAN L. RICHARDS has been appointed to the Royal Naval Hospital at Gibraltar, and SURGEON RICHARD F. CLARK to the *Empress of India.*

STAFF-SURGEON JOHN DAWSON has been appointed to the *Repulse*, SURGEON LAWRENCE BIDWELL to Plymouth Naval Hospital, and SURGEON ARTHUR R. BANKART, M.B., to the *Osborne.*

COLONEL W. E. SAUNDERS, C.B., R.A.M.C., in medical charge of the Station Hospital at Mhow, Bombay Command, has been ordered to return to England at once, to assume the duties of Principal Medical Officer of the North-Eastern District; LIEUTENANT A. MILLAR, M.B., I.M.S., is promoted to be Captain.

SURGEON-CAPTAIN E. REID, 3rd Glamorgan Rifle Volunteers, has resigned his commission.

MR. ERNEST H. TIPPER has been appointed Surgeon-Lieutenant in the 1st City of London Artillery (Eastern Division, Royal Garrison Artillery).

Solution to Case for Diagnosis, page 594.

Post-mortem.—The liver contained a large number of pyæmic abscesses and there was suppurating clot in the portal vein. The liver was adherent to the diaphragm and reached as high as the third rib, the whole of the lower lobe and part of the middle lobe of the right lung being collapsed above it; there were also about ten ounces of fluid above the diaphragm. The appendix was bound down to the cæcum by old adhesions in which lay a concretion which had ulcerated through the appendix. An inch from the origin of the appendix was a fistulous communication between it and the cæcum; there were no signs of recent inflammation.

ED.—H. L. E.

Contents.

	PAGE
The Physical Society	409–418
The Annual House Dinner	418–419
Chapel News	419
Notice	419
Correspondence: Herpes Zoster	419–420
Guy's Hospital Medical School	420
The Guild of St. Barnabas, for Medical Students	420
Nursing Notes	420
Passim	421–422
Growth of the Large Intestine: Clinical Lecture by Mr. Dunn	423–428
Hospital News	428
De Gustibus: A Tragedy	428–430
Nursing News	430
A Library for Nurses	430
Papers by Guy's Men	430
The Nurses' Choral Society	431
Metropolitan Asylums Board: Fever Instruction; Notice to Students	431
Sport: Rugby Football; Association Football	431–43[illegible]
From the Gazette's Special Pathologist	432
Appointments	432

Calendar of Coming Events.

October, 1899.

Sat. 7.—Messrs. Lucas and Lane's take-in; Drs., D. G. Greenfield and P. W. L. Camps; Cl., W. B. Secretan.
1 p.m., Clinical lecture by Dr. Pitt.
G.H.R.F.C., I.—Kensington, away.
II.—Kensington, home.
III.—St. Paul's School, II., away.
IV.—Park House "C," away.
G.H.A.F.C., I. & II.—Trial Games, home.

Tues. 10.—Final Conjoint Examination begins.
Meeting of the Dental Society at 4.30 p.m.
Schedules for L.D.S. Eng. to be left at the Medical School Office with the Certificate of Mechanical Dentistry, signed, not later than this date.

Wed. 11.—1.15 p.m., Clinical lecture by Mr. Davies-Colley.
G.H.A.F.C., I. & II.—Trial Games, home.

Thur. 12.—Messrs. Golding-Bird and Dunn's take-in; Drs., E. J. F. Hardenberg and J. F. Robinson; Cl., L. Wilkin.
G.H.C.U.—Address by Rev. W. R. Mowll.

Sat. 14.—1 p.m., Clinical lecture by Dr. Pitt.
G.H.P.P.S.—Clinical meeting.
G.H.R.F.C., I.—Lennox, home.
II.—Lennox, away.
III.—Croydon, III. (4 p.m.), away.
IV.—Old Alleynians, III., away.
G.H.A.F.C., I.—Old Harrovians, home.

Wed. 18.—1.15 p.m., Clinical lecture by Mr. Davies-Colley.
G.H.R.F.C., I.—Cambridge, away.
II.—Westminster Hospital, home.

Thur. 19.—Messrs. Howse and Jacobson's take-in; Drs., H. G. Rashleigh and L. Pern; Cl., R. C. Mullins.
G.H.C.U.—4.30 p.m., Annual sermon by the Ven. Archdeacon Sinclair, D.D.

Sat. 21.—1 p.m., Clinical lecture by Dr. Pitt.
G.H.R.F.C., I.—Old Leysians, away.
II.—Old Alleynians, home.
III.—Surbiton "A," away.
IV.—Mortlake St. Mary's, away.
G.H.A.F.C., I.—Godalming, away.
II.—L.C.C., home.

Guy's Hospital Gazette,

OCTOBER 7, 1899.

The Physical Society.

Sir Samuel Wilks presided at the opening meeting of the Physical Society, which was held on Monday evening October 2nd, and at which the members mustered in goodly number. The secretary having read the minutes of the previous meeting,

The Chairman said: Gentlemen, I am here to-night as president of the Physical Society. I am glad this is the commencement of a new session, and as there are, I hope, a great many new men here, it is my duty to make a few remarks. To the new men who are here I offer my congratulations upon their having entered on the session, and in all modesty I may say I am not at all displeased that you have chosen Guy's Hospital—(applause)—as you will find the whole machinery here in perfect order for the work that you will have as students. And this I may say with the greatest confidence, that there is no school in this country where you will find your teachers more willing, and more devoted to and interested in their important work of imparting knowledge. I believe you may feel, and justly so, that you have connected yourselves with a school than which none has produced more illustrious alumni. (Applause.) Well, when I say I congratulate you upon entering the medical profession, you must remember that you are here in the presence of one who has borne the heat and labour of the day, and whose career is coming to an end; and, therefore, I may say with all sincerity, that in looking back upon my past career I look back upon it with pleasure. (Applause.) All the little bickerings and the disappointments and the feelings that we have had when our patients did not sufficiently appreciate us, the ingratitude of some, and the occasional success of charlatans—all this is in the past; it is very little in my mind, and I have almost forgotten it. But what I do remember with pleasure is the time which I spent in this hospital in what is called scientific work—pathological work. The time that I spent in the museum was most interesting work. And then, perhaps, above all I look back with pleasure to the time that I spent in educating the students in this hospital. (Applause.) Although that time is past, I still think that I have your sympathy, devotion and

affection. (Applause.) Therefore, I can look back calmly and coolly on the past, and say with all sincerity that I do congratulate you on entering the medical profession. That profession is interesting in many ways. One has only to compare it with other employments. Some of you, perhaps, have a brother in a bank —(laughter)—earning money thereby for the support of his wife and children. Well, he may have an interest in it; I cannot understand the interest. (Laughter.) But look at yourselves in the medical profession, look at your daily duties—how interesting they are! Think how every day you have a case, medical or surgical, bringing with it a great amount of anxiety, no doubt, but how can you have pleasure without corresponding anxiety? And then think, educated as you are in matters scientific, what a number of other interesting subjects you may study outside the actual practice of your own profession, such as heredity and questions of that kind—all of the greatest interest. I think that every medical man ought to have some other occupation besides his own. You may look at the stars above you and study astronomy; or you may do as our friend here has done, not only look into organic nature, but look into the earth itself, and see how that has been made and formed through ages and ages. And more than that, there is real interest in everything that is living—in the fact, for instance, of how development has gone on from the earliest forms of life up to the present time. All these things seem almost naturally to come before a man who has had a medical education. In taking up a medical journal one is interested now and again in seeing how, at some time or other, some medical man who has retired, perhaps, has had some presentation made to him, and is the leading man in his own town. And that is just what I would like you to be. You begin by attaching yourself to a hospital, and then you become interested, if you like, in civic matters, and presently you become chief magistrate. (Laughter.) You may say this is the good side of it. Well, it is the good side, and why should you look upon the other side? If you work hard at Guy's Hospital and are industrious, and go into practice in any town and lead an honourable and straightforward life, there is room for you. Of course, there is the other side. There are cases where men ought not to have entered the profession at all. It was only the other day that I met a man who was doing very well as a farmer in the Colonies. I know that that man's father tried to make him work hard with a view to his entering the medical profession, but the man was not fitted for it, and he said to me privately, "It is no good; the look of a book makes me sick!" (Laughter.) Then there are other men who, unfortunatey, do not get on in the world. These are men who come here and pass examinations, but they are incapable in their profession—a class of men that my friend Dr. Savage was lecturing upon. (Laughter.) They are not fit for anything. I know two gentlemen who were brought up for the bar, very clever men, and they never could earn a shilling in their lives. There are, unfortunately, in the present day, degenerate persons of that sort. But I am supposing that a man has ordinary common sense, and works hard at his profession, and leads an industrious and honourable life, and to such a one I say there is room for you. So long as England exists there must be people, and so there must be doctors. We must have our preachers, and bakers, and lawyers, and parsons, and there will also be doctors, and those who do their work well will come to the front, and the others will not. But I wish to put the good side before you, and I put my own case before you. When I review my life professionally, I have reason to do so with pleasure, not only because of my relations with the students, but also with the friends I had in my colleagues here, and, I may say, in the profession at large. (Applause.) Of course, when I read the medical journals I constantly see this other side of the question, and I do see sometimes, in addresses written by even eminent men, the expression "our long-suffering profession." Now, what that means I have not the slightest idea. (Laughter.) But the gentlemen who use such terms as that seem to think that we want protection from the Government, and they talk of asking Parliament to suppress quackery. The thing is absurd—(laughter)—it will never be done. Parliament has done so much; they have given privileges to those who are qualified, and I rejoice to think that they will do no more. The idea, as I have said, is absurd; much more absurd is it than to suppose that the profession is to be kept pure by a Medical Council condemning those who do wrong. For forty years they have had the power to take men off the list who do anything which is proved to be abominable in a professional sense. If, for example, a man goes into practice and sells himself to a contracting company for so much a year, so that those people may make something out of

him. That is a very unprofessional and disgraceful thing for him to do; none of you would think of doing that. Or you perhaps go into a town for a practice, and there is some post vacant. You hear that that appointment is worth so much, and the medical men in your neighbourhood say it ought not to be done under a certain salary. Well, if you go and undersell them you do a very dirty and disgraceful thing. But Parliament can do nothing in a case of that kind. And so I say, that if you follow a legitimate, and industrious, and honest course, then you will succeed. Of course, there are differences in medical men, and even if certain men are honest and upright they will not succeed as well as others. But if they do not succeed in one way they will in another. Our profession is both an art and a science. Some men succeed in their profession as an art; they know how to use their medicines and manage their patients, and no man who has not that power will prosper in the art of his profession. But then he is perhaps fond of science, and he has associated himself with a number of scientific societies, and he has raised himself by the work he has done. I have in my mind's eye the case of two gentlemen residing now in the same street. One man had the power of getting on in his profession, especially from a monetary point of view, and before long he was seeing a large number of patients, and everybody in the neighbourhood knew that he was attending a princess. (Laughter.) I may say the princess was living at Brighton; he had to go down and see her at Brighton, and one day she disappeared, and he never got one penny. (Laughter.) The way in which this man was succeeding in his practice was thrown in the teeth of the other man, but the latter continued to follow his own pursuit, and now at the present time, after many years, the first-named gentleman is still going on with his practice, and is still making money, I suppose—I see him driving about now and again—whereas the other man has attained every honour that the profession can give. Some time ago I took up the *Spectator*—not the modern, but the original *Spectator*—which I always find is very good reading, and I came across what is constantly being quoted, written by Addison nearly two hundred years ago. Of course, the profession can bear a good deal of criticism, and speaking of medical men, Addison says:—"This body of men in our own country may be described like the British army in Cæsar's time; some of them slay in chariots, and some on foot. If the infantry do less execution than the charioteers, it is because they cannot be carried so soon into all quarters of the town and dispatch so much business in so short a time. Beside this body of regular troops there are stragglers who, without being duly listed and enrolled, do infinite mischief to those who are so unlucky as to fall into their hands. There are besides the above-mentioned, innumerable retainers to physic, who for want of other patients, amuse themselves with the stifling of cats in an air pump, cutting up dogs alive, or impaling of insects upon the point of a needle for microscopic observation; besides those that are employed in the gathering of weeds and the chasing of butterflies, not to mention the cockle-shell merchants and spider-catchers." (Laughter.) Well, Addison knew better than that, though certainly at that time the profession deserved a good deal of criticism, but those things are now past; and the moral of my remarks is just this, that the medical profession is the most interesting profession that you could name, and if you conduct yourselves in an honest, and industrious, and proper way, there is a living for you. Of course the weakest ones go to the wall in all professions, but I think I may honestly, in looking back at my past life, congratulate you on entering the medical profession. But you must remember, to quote the words of Bacon, that "A man should do something for his profession." If the profession has made you respected in the town to which you have gone, you must do something also for the profession; you must remember that you are not independent of that, and in a lesser degree you must remember the institution where you were educated, Guy's Hospital. As soon as you put your name down here as a student you are no longer a free man, but you have got to think of Guy's Hospital. (Applause.) It is a place of great celebrity and you must do nothing at all to disgrace it, but you are to keep it up in its fame. I need not say more. I did not intend to address you at any length, but I cannot do better than end what I have to say by a few words from an address that was given at Guy's Hospital, in the year in which I was born, by Mr. William Allen, a distinguished chemist, who was also professor, as you know, at the Royal Institution. He says at the end of his address: "The profession you have assumed is one of the most respectable of which man is capable. Having carefully studied the nature of our frame, you have undertaken to soften the miseries to which it is liable. May you, though in an inferior degree, endeavour to

imitate the great example of Him who went about doing good, healing all manner of diseases. In a world so full of woe, to a noble and generous mind the opportunity of soothing the brow of care and drying up the tears of sorrow are the most gratifying offices which it is called upon to fulfil. Upon you will the anxious eye of the maternal head of a family be fixed in all the anguish of grief, while the support of herself and helpless infants is stretched upon the bed of languishing, and if poverty be added to her affliction I trust you will rise superior to sordid views, and find your richest recompense in the approbation of your own minds, in the sweet satisfaction of attempting at least to diminish the weight of that misery which perhaps from the nature of things you cannot wholly remove. I am aware that in the line of your profession you will be sometimes placed in difficult and delicate circumstances, but never, I entreat you, sacrifice your sense of propriety, your feeling of the eternal obligation of right and wrong, that on which your present and future peace of mind depends, to any prospect of sinister advantage. So will you in your different circumstances be the instruments of most extensive good; you will be a blessing to your country, and honoured by those whose good opinion is of value." (Applause.)

Dr. Wheelton Hind then read his paper on—

GEOLOGY AS A HOBBY FOR MEDICAL MEN.

Mr. Chairman and Gentlemen,—When I received an invitation from my friend and your secretary, Mr. Targett, to come up and read a paper at the opening of the session of the Guy's Physical Society, I took it that it was more or less of a command, and I felt that the honour was one that could not possibly be refused. I must confess, too, that the temptation to come back again to Guy's, if only for a brief moment, was one not to be withstood. It is just twenty-one years since I entered Guy's, and, alas, fifteen since I last took part in any function within her walls. One can hardly consider a temptation of any moment if it does not compel one to give way to it, and, therefore, I could not but acquiesce in the request; but I cannot help recognising that at Guy's, where the powers that be have for a long period decided that there shall be no formal opening address such as obtains in nearly all other medical schools, the position of him who opens the session of the Physical Society is a most important one, and no sinecure.

To a certain extent, indeed, Mr. Targett considerably lightened my task in presenting me with a subject all cut and dried, so that I was freed from the usual initial difficulty which generally crops up on such occasions, viz., the search for a subject, but on the other hand, his choice of "Geology as a Hobby for Medical Men" created a difficulty of another kind in that it necessitated the attempt on my part to interest you in a branch of scientific knowledge which has little or no contact with the healing art, with the exception, perhaps, that in the study of Public Health it is useful to have some small acquaintance with a few elementary ideas about the general structure of the rocks which form the crust of the earth, and some knowledge of the subject of underground water, which might be termed applied geology, rather than any study of that science on its own merits.

Now, my subject can naturally be approached from two points of view. First of all, there is the question of the desirability of a hobby, and secondly, the suitability of geology as the subject for a hobby.

No one will, I think, be bold enough to deny that change of occupation, recreation and rest are absolute necessities for every worker, and it is found that nearly every one who is worth his salt, in every rank of life, has some hobby or subject to which he devotes his leisure. It may be either some form of mental or physical culture, or the care and breeding of pet animals. According to natural bias and personal idiosyncrasy, one man cultivates some form of art, music, decoration or pure literature, another has a liking for purely mechanical work; others, again, give themselves up to the gentler task of horticulture, while others prefer to select some branch or other of pure science in which they may specialise, finding a small area of untilled ground to exploit, or a small niche, hitherto unoccupied, which they can fill.

There is no doubt that the hardest workers seem to find the most time to devote to extraneous pursuits, and that change of subject forms a quite sufficient and absolute form of rest, just as a series of muscles when weary can obtain the necessary rest by change of action. It is very noticeable, when tired out by a long bicycle ride, how restful it is to walk. Monotony is always fatiguing, whether it be monotony of work or idleness, and the life to strive for is a many-sided one, every moment of which is occupied by subjects of diverse interest.

I know I may at once be met with the argument that, owing to the many-sidedness of medicine, there is not such a necessity of a change of subject for medical men, and that as medicine embraces such a wide field that life is too short to take up another scientific subject. I hold most strongly that it is impossible, and most inadvisable for a man to attempt to make a hobby of the work by which he earns his daily bread. To do so must narrow his general view of life, and must trammel and restrict the work itself, for the exigencies of daily bread, and the struggle for existence or fame are hard task-masters, and owing to these factors and to the absurd grandmotherly legislation, which in this country restricts originality and research in medical subjects, the average practitioner can do little more than devote himself to purely clinical work.

Much, however, as medical men may love their profession, they must, for obvious reasons, have some hours of leisure to devote to a hobby. It seems to me that if a medical man has nothing to interest him outside his work, there is a great tendency to make the simple growth of one's clientèle, the increase of the practice, become the *Ultima Thule* of existence, and to measure one's success by the quantity rather than the quality of one's work. Such a state of things is by no means desirable, it warps the mind, fosters jealousy, and leads to anything rather than a friendly spirit amongst one's colleagues and competitors. Unfortunately, examples of this mental attitude are not at all uncommon. High-minded and honourable, well educated medical men, are not rare whose horizon is bounded by "the Practice" spelt with large capitals, who I feel would be somewhat happier themselves, and much more appreciated by their fellow-practitioners, if only they had some other interest in life than the growth of their work. Our work, too, amongst the sick, our large share in human sorrows, the grave responsibilities which rest upon us in the case of important lives at critical moments, demand another and a brighter side to our lives, and like all enthusiasts here I am with my remedy, to cure all the troubles of medical life, not however as a quack, an empirical one, but a remedy based on personal experience. Naturally one praises the bridge which has carried one safely over the stream, and I for my part cannot but testify to the great benefit I have derived from geology as a hobby, and am bound to confess that life has been distinctly more worth living because of the pleasures I have derived from geological research, and I cannot but hope that at the same time my intellectual powers have been improved by the mental and moral training of work in natural science, and that this has resulted on the whole in distinct benefit to my patients, and to my medical work. Medical men, from their scientific training, are so well fitted to follow out some line of research in natural history, and have such golden opportunities for doing so, that they should on no account neglect to turn their spare energy in this direction. All medical students, but more especially those who are working for university degrees or the higher diplomas, obtain a certain amount of systematic education in elementary science, in the shape of chemistry, physics and biology, which form the basis for the study of medicine. Too often these sciences are hurried over—shall I say crammed up—for the mere purpose of examination, and not regarded at all in the correct light. Medicine seems to me to be the application of the laws of other sciences for the purposes of the preservation or restoration of the physiological purposes of health, and, therefore, the larger and wider knowledge we possess of these sciences the better practitioners we shall become. I well remember the erroneous view I took of the matter when I was working for the Preliminary Scientific, how one was tempted to question the utility of such studies, which then seemed to be such a dead weight to be overcome in the limited time allotted to them, and to possess such a doubtful value, even when acquired. But, looking back, with the fuller knowledge of attainment, it is easy to recognise what an important part the study of scientific method and the elementary laws of science play in the training of intellect and the evolution of the medical man. Even, too, if it be denied to some of us to obtain the hall-mark of a degree, it must be remembered that gold has not always the guinea stamp, and that, in the long run, time spent over the preliminary science work cannot in any way have been lost or ill-spent, but will bring in large dividends in the near hereafter, for I take it that it is impossible to study any subject for a year without a certain amount of real benefit accruing.

There are, it is true, many directions in which men may turn their scientific training to account, but it is my duty to-night especially to sing the praises of geology as a hobby for members of the medical profession, and I personally feel that I ought to have little or no difficulty in conclusively showing that of all subjects geology and its cognate branches is a most suitable one for their leisure hours on account of its many-sidedness, its breadth of view and its depth of interest. But, in all fairness, one must not forget that there are many other branches of science in which medical men may dabble with advantage both to themselves and the scientific world, such as botany and the various pursuits which come under the head of zoology. Chemistry, too, may attract, but chemical research is limited by the necessity of laboratory accommodation and the expense of apparatus. As a *dernier ressort* there is archæology; I long to face the devotees of this subject. I think it can hardly claim to rank as a science, deeply interesting though it be, but as a factor in education, being purely empirical in its methods, and deductive rather than inductive in its modes of thought, it cannot attain to the level and importance of biological or chemico-physical subjects.

It seems to me that geology and medicine have at least this in common, that the would-be student must have a knowledge of the laws of nearly all other branches of science before he can approach either of them, and, therefore, in taking up the study of geology, medical men start ready equipped for their work, having already acquired the elementary scientific knowledge necessary as a basis for the study of that subject. Owing to the wide field embraced under the term geology, and the many different lines on which research can be carried on, a man may follow his own bent, and specialise in any direction which particularly appeals to him.

A wide investigation lies open in the mere chemical analysis of rocks, or if more difficult and higher flights should attract, there is almost a virgin soil to be tilled by those who would experimentally examine by synthetical methods the various rock-forming minerals, and suggest some idea of the chemico-physical conditions under which they are formed naturally.

And who so well fitted to take up the microscopical work, so important a method of observation in the

subject of petrology (which is the study of the crystallography, nature and appearances of rocks) by the examination of their transparent sections; and microscopists, with a biological bias, would find untold interest in the study of the minute fossils which form so large a portion of some sedimentary rocks, especially those known as limestones, which are composed of almost pure carbonate of lime, and of flint or chert, or colloid oxide of silicon.

And speaking of fossils, can any one resist the curious charm which these relics of creative energy possess? Nearly everyone, be he interested in geology or no, picks them up, and they play a most important part indeed, both as an attraction and introduction to the science, and in a more special way serve as the basis for the classification of rocks, and become the, so to speak, chronometers of geology, for by their aid the relative ages of the beds in which they occur can be to a large extent estimated. Many a man who has risen later on into eminence in the geological world, has been induced to take up the study of that science because the fossils belonging to the rocks of his own district attracted his notice, and from the mere collector of natural curiosities was evolved the student. There seems to be a very widespread inclination, which almost approaches to an instinct, to pick up and collect curiously shaped stones. Do we inherit this almost universal character from our ancestors of the stone ages, who chipped out their weapons of offence and defence from certain rocks, and keen to observe, made use of fossils as talismans or charms? The cottage window with its little heaps of stones and fossils, the cabinets of the better classes with their brighter minerals and spars, the rockeries and grottoes of the gardens formed of local stones, whose fantastic shape or attractive appearances have demanded attention, all point to the universal cult of stones. The definite shape of crystals and fossils alone attracts observation, a transparent, six-sided prism, a shell or leaf in stone, quasi miracles, exciting wonder and imagination, demanding answers to the questions, What, How and Why? which, if only followed up by the necessary amount of observation and enquiry, must beguile the questioner into the absorbing study of geological phenomena.

The study of fossils, or paleontology, is, in all conscience, wide enough. Each system of sedimentary rocks has its own peculiar fossils, for as a tree is known by its fruits, so with equal accuracy the rocks are known by their fossils; and not only has each main geological subdivision its own organisms, but frequently each separate bed of that division is characterised by some special organism, whose life-history was coeval with the formation of that bed. Fossils of all the great orders, families and genera of animals and plants are known, from the microscopic foraminiferæ, whose cases form so much of the limestones and chalk, to mammals, not excluding the genus *Homo*, whose bones, teeth, and weapons are found interred in the muds and sediments of ancient rivers, lakes and seas. Amongst these are many species, waiting for their coming Adam to name and describe them—for one of the charms of paleontology is that the field is so large and so much is yet virgin soil, that the observer may to a small extent play the part of his mighty forbears, Linnæus, Cuvier, and Lamarck. Surely in the whole of living or dead organisms there is one group or other which will appeal specially to each man, and not only rouse his interest to observe its form and its anatomy, its relations to allied animals, both fossil and recent, but will also make him try and work out the history of its race; the phylogeny and ontogeny of fossils forming a subject more attractive to those of a more purely philosophical turn of mind.

Wide as is the known field of paleontology, probably very many forms have never yet been unearthed from the rocks which contain them; therein lies one of the great charms of fossil hunting. The unexpected is always happening, and any chance blow of the hammer may reveal an organism never known or seen before. And even if brand new discoveries do not reward one's labour, the observations of the occurrence of known species in new localities is most important from its bearing on the physical geography of the different geological epochs, and small portions of fossils may be found in such a condition as to reveal internal anatomical structures of great importance for purposes in classification, or for the study of the life-history of an organism whose age is so great as to be unthinkable.

I might, too, enlarge on the sentimental side of the question, and the many forms of pleasure which are indissolubly bound up with fossil hunting. There is all the pleasure of the chase without the suffering of the pursued, and the excessive physical exertion necessary to most of the so called sports. The healthy out of door exercise, the escape from crowded haunts to the green and rocky slopes of the hillside, or the pleasant shady glen and streamlets which have been working hard for the fossil hunter by dissecting out the various beds of rocks for him, and laying bare the rich treasuries of organisms contained in them. The work in the pure free air, surrounded by river, rock and tree, the scenery forming a temporary environment whose charm is inimitable. In addition to all these pleasures there is that of a higher and more intellectual kind in observation and discovery, the increase in actual knowledge, and the development of the science of geology.

The spoils of the working paleontologist are so peculiarly his own, earned by honest toil, and hitherto unseen by mortal eye since the day they became covered by slowly accumulating mud of the sea bottoms, æons of ages ago, each to play its small, but necessary part in the formation of the earth's crust, if it did not also play its part in the actual development of the human race. Is it indeed purely fanciful to suggest that any of the older, and more lowly organised fossil forms may have been in the direct line of our ancestors, an actual progenitor of mankind? Nor does interest in fossils cease with the find; much, too, remains to be done when they have been safely conveyed home. A large amount of careful mechanical manipulation is often necessary to fully free

the specimen from its matrix, and to expose parts which are regarded as of specific importance in the final classification of the specimen, and in the diagnosis of the identical species to which it belongs. Then it must be mounted and labelled, and placed in its own proper position in the cabinet, and finally must be studied from a purely biological standpoint, thus forming an occupation for leisure hours spent perforce at home.

There is still another side to geology, the stratagraphical, which consists in the study of the relative positions which the various beds of rock occupy to each other in the field, and the observation of the horizontal extent of each stratum over the country-side. This is of course purely field work, and this branch is largely undertaken for the purposes of making maps, and for economic purposes such as the supply of water, coal, minerals and building stones. This branch of work, however, cannot be thoroughly carried on without a knowledge of fossils, for in cases of doubt, fossils are always trumps, and the final appeal is always to the paleontological evidence.

Geology, like the poor, is with us always, and must obviously obtrude its phenomena constantly upon us, though perhaps it may be said that those who go down to the sea in ships are not in the same position as those of us who stay ashore; but every sea connotes a shore, and it is in the rocks exposed on the sea margin that special opportunities occur for observing the structure of the earth, and the wider opportunities of travel give a great field for observation, which being not in our own country, the general law of the Prophet, applying to things as well as men, is more readily looked at and more highly honoured. The majority of medical men are fated to practice in the provinces and to become the much criticised G. P. Why do all hospital men in their callow days of studentship look down on the class to which they are fated to belong, I wonder, and who after all are not such impossible people as the patients, on whose evidence alone they are judged, would make them out to be? I think it must be a cardinal doctrine amongst patients that when talking to another medical man of what a doctor has said to them, to draw a very long bow, and to make up for what they may deem an insufficiency of evidence by the romancing of a most vivid imagination. But this is all by the way.

As men whose work necessitates that they must cover some fairly large area of country each day, medical men often get to know their own districts like a map, and cannot help noticing the various quarries, brick, sand, and stone pits, which are dotted about all over the country. They come into actual contact with the owners and workers themselves, who are only too pleased if their doctor takes an interest in their work. Hardly a walk or drive can be taken without some or other sort of work obtruding itself upon our notice, silently, but forcibly, demanding explanation because of the scientific training and the cultivation of the powers of observation. Geology is a grand stimulus to out of door exercise. It gives an object to each walk, it encourages the busier men to take the necessary active recreation, which as years pass on and the demands of practice increase they feel tempted to dispense with altogether to their own detriment. It adds zest to the annual holiday, making it a *sine qua non* for the purposes of working out some geological problem, or obtaining certain minerals or fossils, and notwithstanding the locum, occupies his mind so thoroughly while away that he can forget that he is a medical man or has a practice at all. I well remember one day in the wards the late Dr. Hilton Fagge telling us after he had been away for a short holiday—if my memory serves me correctly he had been fishing—that he forgot completely all about his work when on his holidays, and dressed as a fisherman in the pursuit of that gentle art on this occasion the thought came to him, Is it possible that I the fisher was a consulting physician in London and physician to Guy's? I must confess, too, that once I get into the train on a geological expedition my mind becomes a complete blank on medical matters, practice included, until the moment when I arrive back again, when one is pleased to find that my powers of diagnosis or of treatment are not "such stuff as dreams are made of," but are as real and unimpassioned as "the beauteous fabric of a vision" they were before setting out.

Am I too severe in thinking that many medical men waste their hard-earned and richly-deserved holidays, frittering them away in mere sight-seeing, or devoting them to banalities? Perhaps I may be judging others by my own temperament, for I feel that a holiday without any definite work would make me miserable and bad tempered, an observation based on experiment I can assure you, and I suppose in justice I ought to allow that there may be many who can obtain the rest and ease they want in doing nothing; still, on the other hand, they are members of a community and have a duty to the world of science and intellect not to waste the opportunities for special work which they, more than any other class of men, possess.

Time is very apt to hang heavy on the hands of a large number of young medical men who are beginning to practice—in fact they have more leisure than is either pleasant or profitable. At the same time, discretion dictates that the greater part of this time shall be spent within a reasonable distance, if not immediately behind the spick and span brass plate. Here, then, is the golden opportunity to take up some branch or other of scientific study, especially one which can be carried on to a large extent at home. Of all subjects, what could better suit the requirements of embryo practitioners than geology? The daily constitutional may be occupied in exploring the immediate environment of the future large and famous practice, collecting the specimens of rocks and fossils which can be examined and worked out in the enforced leisure hours at home, helping to keep green the scientific knowledge acquired during medical training, and not permitting that knowledge to fossilise and become submerged, buried up by a matrix of detrital and unproductive matter.

Now, putting the case on lower grounds, is it impolitic to pursue such a course from mere motives of self

interest? All over the country scientific societies of more or less importance are established, embracing amongst other subjects geology, which seems, as a rule, to attract the largest number of adherents. Active membership in these societies gives a man a certain local status, not to be despised I can assure you, and, besides, an introduction to a much larger circle of the more intellectual people of a district than is otherwise easily obtained. The opportunity of reading original papers and taking part in debates affords an opportunity of showing fellow-citizens the weight of metal one carries, and serves as an index to one's mental and scientific acquirements.

Going back to my first appearance, as a freshman, at the Guy's Physical Society, I remember well hearing Sir Samuel Wilks read a letter from an old Guy's man, away in the colonies, who had just been returned either as a member of the government, or a member of the house over there—I just now forget which—in which he stated that unless he had had the introduction to debate which he got in this society, he felt he should never have taken to a political life. And this is a statement with which I am strongly inclined to acquiesce, but I would go further, and say that the opportunities for reading original papers and debating on the theses of others is the strongest stimulus to the creation of original work, and just as Sir Samuel Wilks has always insisted on the high educational value of the Physical Society to all Guy's men, and has demonstrated the strength of his belief by coming to the opening meeting session after session, I would advise all new comers, and even those older men who have neglected these opportunities hitherto, to allow no engagement to prevent the regular attendance at the Physical Society. But alas, though as scientific Guy's men, we are perpetual students—and I use the term perpetual in a larger sense than it denotes in the green book—we cannot all of us stay at Guy's for more than a brief span, much as it may have been our ambition to do so, and it is necessary to seek a new arena for the display of scientific energy, and fortunately for us the local societies are waiting with open arms to receive us and to continue the good work that the Physical Society has so well begun.

As I hinted above, one branch of medical science does come into close contact with geological phenomena, for certain questions of public health are intimately dependent on a correct appreciation of them. It is important that the nature and lie of the rocks of any district or town should be known in constructing a system of drainage or water-supply for that area; or the permeability or not of certain rocks by water, for the underground water-supply is naturally contained in porous rocks such as sandstones, and beds of clay or other impervious rocks serve as factors which limit the extent to which water will sink below the surface. In the choice of sites for public and private buildings, it is essential that the nature of the ground should be accurately known. Drains laid in a porous rock are obviously most liable to contaminate the water held in its pores and to become a very fertile source of danger. The great questions of water-supply are absolutely dependent upon accuracy of geological knowledge, be it a simple well sinking, or the damming up of a valley and the formation of a lake by the impounding of a large catchment area.

The mere question of density of population, too, is governed by geological factors. Naturally the strata which contain coal and iron, will have the largest number of beings per mile upon them, the easily disintegrated rocks will form the agricultural lands and only support a medium number, while the older, harder rocks forming the mountain and hill districts have the smallest population of all. An exception to this statement, however, is the London area.

The position of all large towns and sea-ports is primarily due to geological phenomena, depending on harbours naturally formed by rocks, the proximity of water-bearing rocks, areas for food-supply, and the production of fuel in some form or other.

Nor ought we as physicians to ignore the geological structure of these health resorts, whose *raison d'être* is the possession of springs and medicinal waters. Let me give you an illustration of empirical therapeutics which are really based on sound geological facts.

Bath, Buxton, Matlock, and various other places I could enumerate, are all largely used as resorts for patients suffering from rheumatism and other chronic troubles which flesh is heir to. Why should this be so? Well, in the first place, the large majority of these places are situated on limestone. Limestone is full of joints and soluble in water containing CO_2 in solution. Consequently the rock is full of fissures and holes, and all the rivers and streams flow underground. The result is that even after heavy rain the ground soon dries, and the air of a limestone country contains a much smaller quantity of moisture on the average than other districts. I have found in consequence that the skin acts much more readily, the amount of perspiration is largely increased, the amount of moisture given off by the lungs and kidneys is diminished. In chronic bronchial congestion the immediate result of a trip to a limestone area is seen at once in relief from wheezing and the other discomforts of this ailment. In rheumatism, this increased action of the skin is supplemented by baths and the administration of the various local waters, which keeps up the diuretic action of the kidneys and increases the action of the intestinal mucous membrane, and so elimination from all the excretory glands is much increased.

Rainfall, too, is considerably affected by the geological structure of the country. An example of this is found in North Staffordshire, where we have a larger rainfall than our neighbours, because we are situated at the south-west corner of the great Penine upheaval, which deflects the clouds, turning them downwards till they reach the lower grounds and foothills of the upper Trent basin, and the presence or absence of forests is absolutely dependent on the constituents of the soils which are formed by the breaking up of the rock below.

In short, can one postulate that either botany or any of the hobbies which have a merely biological basis have so important a connection with medicine, or are so useful and necessary to the medical man as geology? I think not, and I hope I have conclusively proved my thesis, but I will adduce one more argument which I regard as strongly in my favour, an argument, too, which if elaborated might be made statistical. The proof of a pudding is in the eating, and geology has not failed to attract a fair number of medical men, many of whom have made their mark in the history of the science. James Hutton, the father of British geology, was an M.D. of Edinburgh, but preferred to devote himself to science rather than practice as a physician.

The fourth, sixth, eighth and ninth presidents of the Geological Society, founded in 1807, were medical men, and out of forty-seven persons who have held that office, eight were doctors. A medical man is director of the geological survey of New Zealand, another is assistant director of the geological survey of Canada. The late Mr. Hulke, the eminent surgeon of Middlesex, whose acquaintance I first made at the little tables in Lincoln's Inn Fields, and I found him none the worse surgeon for being a geologist too, also held the office of president of the Geological Society, and achieved fame as a student of the osteology of extinct reptiles and mammals. Will not this fact give some of you an added inducement to apply yourselves more thoroughly to that dry subject, bones. And, indeed I might fill pages in telling you of men like the late Professor Martin Duncan, whose speciality was the study of fossil corals, who left his practice in the eastern counties to become professor of geology at King's College; of the late A. Nicholson, of Isaac B. Balfour, T. Traquair of Edinburgh, the latter an authority on fossil fishes, and keeper of the Science and Art Museum, of Edinburgh; of the greater lights, Huxley, Owen, and Flower, whose original medical training we are apt to forget; of the great John Hunter, too, who collected fossils and studied them; of Wright and Lycett of the Cotswold Club; and many others whose work I would have you emulate; and not to omit our ever welcome President, Sir S. Wilks, who confessed to me the other day in a letter that though he had never had time to devote to it, geology had always a very great attraction for him. One other name and I have done, and that is R. Koettlitz, the traveller, a contemporary of the latter part of my stay at Guy's, a man who I remember took an interest in this Society, has made many important geological observations on his journeys, and brought certain of his results before the Geological Society.

In conclusion, may I once again reiterate my conviction that geology is pre-eminently suited to be a hobby for medical men, if it be not an essential; and may I assure you that the mental training of original scientific work, the tracing of effect to its cause, the practice of inductive and deductive methods of reasoning, the education of the eye to observe small differences, the training of the hands to skilful manipulations, cannot but react on the individual and on his medical work, rendering his perceptions more acute, and his judgment more accurate and subtle.

Mr. F. E. Walker then moved a vote of thanks to the lecturer for the excellent paper to which they had listened. He thought they owed Dr. Hind a deep debt of gratitude for having laid stress on the importance of medical men having a hobby and spending their spare hours profitably. It was obvious that the subject of that evening's paper was one eminently suitable for country practitioners to take up. Guy's men possessed peculiar facilities for, at any rate, starting the practice of this study. At the present time, as every one knew, excavations were being carried on around the hospital, and he had even treated in the front surgery one of the students who fell a depth of some fifteen feet into one of the pits that had recently been dug. (Laughter.) Moreover, it was only that afternoon that he was looking at a most interesting collection of antiquities—and he took it that archæology went hand in hand with the study of geology—which had been dug up from the bed of a small stream that hundreds of years ago ran beneath the ground now used for Guy's Hospital. Necessitating as it did active employment, open-air work and the like, he believed that the subject of geology was one which should certainly be thought of by a medical man looking for a hobby. (Applause).

Mr. H. W. Bruce seconded the vote of thanks which was enthusiastically passed.

The Chairman said he agreed cordially with everything Dr. Hind had said, except that he preferred the term *pursuit* to the term *hobby* in the connection in which the word was used, and especially so when they considered the number of men in their profession who had distinguished themselves in the study of geology. He had known three medical men who had been presidents of the Royal Geological Society. And he was surprised that Dr. Hind did not mention a Guy's man who was a distinguished geologist. He had mentioned Mr. Hulke as being president, but he had made no mention of another Guy's man who had also become president of the Geological Society — Dr. Hicks. Dr. Hicks started in general practice where he now is, in the north of London, but he took up what they were pleased to call a hobby, and he so distinguished himself in geological work that he soon became a fellow of the Royal Society, and last year he was president of the Geological Society. Therefore they should think highly of geology as one of the subjects which medical men

should take up. His own name was mentioned by Dr. Hind in connection with this subject. It was a subject which he had always been interested in, and it was due to the recollection that Dr. Hind had done a great deal of work in geology that he (the chairman) was induced only the other day to go and look at the North Craig and see how it was made up of fossils belonging to a former world. He thought that every medical man should have some pursuit outside his own profession. Although their profession was really a scientific one, there were gentlemen present amongst them that evening who could testify to the fact of how, as a relief to their ordinary practice, they had studied classics. They remembered how Lord Chesterfield mentioned to his son that he had kept up his knowledge of the classics. Then again, Dr. Babington, the distinguished physician of Guy's, whose statue was in St. Paul's, was very fond of mineralogy, and he amongst others founded the Royal Geological Society. Geology seemed to him (the chairman) to be very intimately connected with Guy's Hospital. (Applause.)

Mr. F. E. Fremantle, in proposing a vote of thanks to the chairman, said that, while thinking with pride of those in all continents representing the various stages of Guy's life, it was also a great pleasure he was sure, to those who were still working at the hospital, year after year, to feel that they met under the presidency of Sir Samuel Wilks. (Applause.) During their course at Guy's, five years or longer, there were two things impressed upon them as incumbent during their time there. One was that they should gain a sound knowledge of scientific learning, both in the general and the specialised subjects that they took up, and to that end they had been inspired by the example of a man who had given his whole life primarily to the scientific side of medicine. (Applause.) The other thing impressed upon them there was the *esprit de corps* that so markedly prevailed amongst all Guy's men. (Applause.) Although the profession at large elected Sir Samuel Wilks to the highest position at their command, nevertheless during the whole time, up to the present, he had kept up his interest in Guy's, and done his best to foster the Guy's spirit. Therefore he (the speaker) begged most cordially to move the vote of thanks to Sir Samuel Wilks, and he felt that the whole society would join with heartfelt enthusiasm in, he might say, that unsolicited testimonial to their president's worth and devotion. (Applause.)

Mr. W. Ramsden, having seconded the vote of thanks, which was most heartily accorded,

Sir Samuel Wilks expressed his thanks for the, he was afraid, too eulogistic remarks which had been made in regard to him. He was very thankful and pleased at having been able once more to come amongst them, because at his age one never knew when he might do so for the last time. However, as long as he lived he would retain his interest in the Physical Society of Guy's, and more especially as belonging to an institution that he had learned to love so well. (Applause.)

The proceedings then terminated.

The Annual House Dinner.

The Annual House Dinner was held in the dining-hall on Monday evening last at 6 p.m., Dr. Pye-Smith coming up from the country just in time to take the chair. There were quite the usual number of men present, and among the members of the Staff and old Guy's men we noticed especially the following:—Sir Samuel Wilks; the treasurer, Mr. Cosmo Bonsor, Dr. Taylor, Dr. Pitt, Dr. Washbourn, Dr. Stevens and Dr. Fawcett, Mr. Symonds, Mr. Dunn, Mr. G. B. Smith, Dr. Starling, Dr. Beddard, Dr. Stevenson, Mr. B. A. Richmond, Mr. Ramsden, Mr. W. H. Crosse and Mr. R. P. Rowlands.

At the conclusion of the dinner, the toast of The Queen having been drunk, Dr. PYE-SMITH rose to propose the health of the Students' Club. He said that it was an invariable rule at the annual house dinner that, owing to lack of time, there should be no speeches, and that rule was invariably broken by the order of one whom the Club must obey—namely, Dr. Fawcett. He would be as short as possible, but a few words of welcome to those joining for the first time would be appropriate. There were plenty of young ones coming on to take the place of those departed, but on looking round the room he was glad to find that he knew most of the faces, and so there was evidently no room for many of the new comers on that evening. He was quite sure that all who had sat down that evening would agree that the Club had discharged its duties well, and he would detain his audience no longer, as he agreed with the old saying that good digestion should wait on appetite, and they all needed an interval before hearing Sir Samuel Wilks in the Physiological Theatre. He would give the health of the Students' Club.

Dr. Fawcett rose and said that he was not going to make a speech, but he would simply ask all present to drink the health of Dr. Pye-Smith. Unfortunately, Dr. Pye-Smith had in some ways retired from the hospital, but it was the good fortune of the Students' Club that he had been persuaded to remain President

for another year—he hoped for longer. He would give them "Long life and happiness to Dr. Pye-Smith."

The toast was received with great applause, and "For he's a jolly good fellow" was sung standing.

Dr. Pye-Smith, in reply, thanked Dr. Fawcett for his kind words, and said it was indeed an honour to be praised by him. He was not yet quite an outsider, and he hoped he would not be for some time to come. Of all the rewards we may look forward to, the greatest is the sympathy and approval of our comrades, and in a place like Guy's, of our pupils. He was glad to say that he had always met with the utmost sympathy from his pupils at Guy's Hospital, and he would thank them all very heartily.

The proceedings then terminated.

Chapel News.

A Series of Addresses to Guy's men has been arranged for the winter months. They will be given in the Chapel on Monday afternoons at 5 o'clock. The dates and speakers are as follows:—

November 13.—The Rev. Canon Taylor, Precentor of S. Saviour's, Southwark.

December 11.—G. W. E. Russell, Esq., late Under-Secretary for India.

1900. January 22.—The Rev. E. F. Russell, Warden of the Guild of St. Barnabas.

February 12.—G. W. E. Russell, Esq.

March 5.—The Rev. Canon Gore, Canon of Westminster.

March 26.—The Rev. Canon Newbolt, Canon of St. Paul's.

The harvest festival is unavoidably late this year. It will be kept on Sunday, October 29th. The preacher in the morning will be the Rev. C. E. Bowden, Vicar of St. Paul's, Bermondsey; and in the evening the Rev. C. E. Brooke, Vicar of St. John-the-Divine, Kennington.

The acting Chaplain will be away from October 15th to October 22nd (inclusive), conducting a mission in the parish of Outwood, near Redhill. The mission is in connection with the Bishop's week of prayer and preaching in the Rural Deanery of Godstone. His work during the time of the mission will be taken by the Rev. G. J. Bayley, Wilberforce Diocesan Missioner.

Notice.

ROYAL COLLEGE OF PHYSICIANS OF LONDON.

Dr. W. A. Foxwell will deliver at the College the Bradshaw Lecture, on Thursday, November 2nd, at 5 o'clock, "The Causation of Functional Heart Murmurs."

(By order of the President),
WILLIAM FLEMING,
Bedell.

(Tickets may be obtained of the Hospital Librarian).

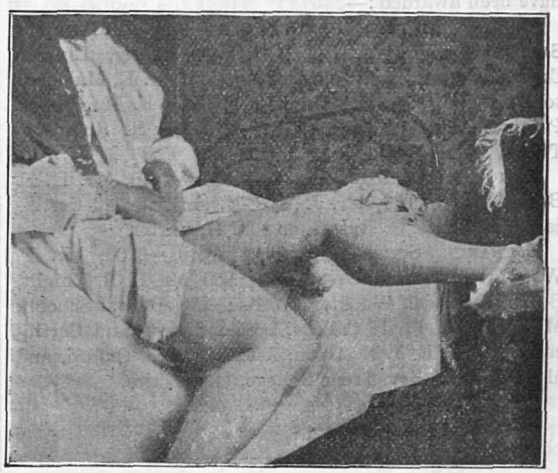
Correspondence.

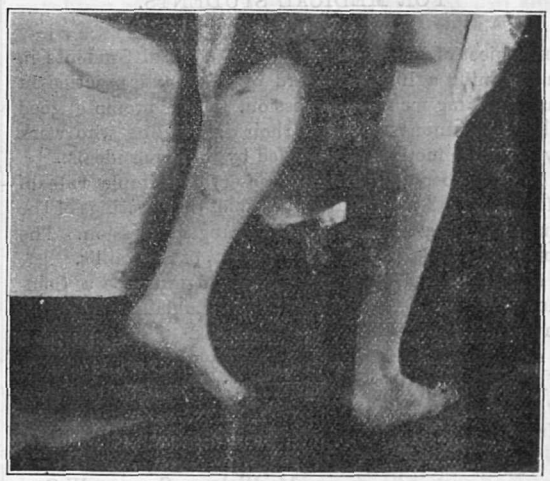
To the Editor of Guy's Hospital Gazette.

Herpes Zoster.

Dear Sir,—Dr. Fagge, writing of Herpes Zoster of the lower limb says, "In the lower limb the distribution of Zoster presents this peculiarity that it is almost invariably confined to the buttock and thigh. Hutchinson says that it never extends below the knee, and the only instance that I know of to the contrary is one figured by Von Barensprung in which there were a few small papules as low as the middle of the calf."

Herein I enclose two photographs which I hope may be of interest to the readers of Guy's Gazette. They





are taken from a case of Zoster, in which besides numberless patches of vesicles following the distribution of the middle and internal cutaneous branches of the anterior crural nerve, there were seven distinct groups of vesicles in the course of the internal saphenous branch as low as the ankle. There was also one small group with four vesicles which is not shown in the photograph, just above the posterior superior spine of the ilium, presumably in connection with the branches supplied to the iliacus muscle by the upper part of the anterior crural nerve.—I am, sir, yours faithfully,

135, Kennington Park Road, S. A. MUGFORD.
September 26th, 1899.

Guy's Hospital Medical School.

The following Entrance Scholarships and Certificates have been awarded:—

Senior Science Scholarship for University Students.—£50, Mr. P. N. Blake Odgers, Lincoln College, Oxford; and Certificates to Mr. G. E. Malcolmson, Owen's College, Manchester; Mr. F. H. Parker, Pembroke College, Cambridge; and Mr. H. Robinson, Trinity College, Cambridge.

Junior Scholarships in Science.—£150, Mr. H. F. Bell Walker; £60, Mr. J. H. Clatworthy; and Certificates to Messrs. G. Russell and H. H. Carter.

Entrance Scholarships in Arts.—£100, Mr. F. Wood, Roan School, Greenwich; £50, Mr. H. S. Knight, Bancroft School, Woodford Wells; £30 (Dental School), Mr. O. Black, Foyle College, Londonderry; and Certificates to Mr. E. J. N. Aston, Jesus College, Oxford, and Mr. H. A. Watney, Trent College, Derbyshire.

Guy's Hospital,
October 2nd, 1899.

The Guild of St. Barnabas
FOR MEDICAL STUDENTS.

The object of this Guild is to assist Medical Students in maintaining a high standard of faith and practice in their training for their profession, and to promote good fellowship amongst those of their own calling who work by the same motives and are led by the same ideals.

The Members undertake to observe a simple rule of life, and to attend, as far as possible, the meetings of the Guild, which are held monthly during the Session. The honorary chaplain is Canon Newbolt, of St. Paul's.

A Student wishing to join the Guild must be a Communicant member of the Church of England, and must have commenced his professional work.

Any Student of Medicine who may wish to know more of the Society will be heartily welcomed on this occasion, or may obtain any further information on application to Mr. Fremantle, the College, or to the Secretary,

B. E. G. BAILEY, Esq.,
14, Woburn Square, W.C.

Nursing Notes.

A few weeks ago when war was looming more nearly in the distance, the Matron had many offers from her nurses to volunteer their services for the Transvaal in case they were needed; we are not sure how many were secretly burning to distinguish themselves, we believe the number was not inconsiderable. Glowing pictures passed through their mind of travelling across the veldt (whatever sort of scenery that may be) in bullock waggons, being enclosed in small forts with the usual handful of British heroes, nursing the sick and wounded, going round with an oil lamp at night, and being so pressed for supplies that even cap-strings must be relinquished for bandages. But none of these sacrifices will be demanded. Owing to the chilly letter from the war office, it seems as if "They weren't taking any."

On Tuesday, in the Matron's dining-room, a meeting of nurses was held to vote a committee for the arranging of the long talked of library. It was well attended, though there were many more night than day nurses. Sister Philip was in the chair; much business was transacted, a president, treasurer, secretary, under-secretary, librarian and a committee of four sisters and four nurses appointed, and the terms of subscription fixed. The power of spending the money and the choice of books to be vested in the committee.

We can only suppose the reason that a vote of thanks was not proposed to the chairman was that the meeting did not disperse *en masse*, but in sections, so that when the result of the voting for the committee was made known, but a scanty half dozen remained.

It is proposed the library shall include fiction, books for reference, poetry, history, medicine and surgery. Let me pause here—let those who read, consider—we should be more than grateful for contributions of Galabin's, Hale-White's and Taylor's great works, or indeed any book likely to be of use to nurses. We are not going to deposit a basket in the colonnade, but the Secretary will acknowledge with gratitude any books sent to the Matron's office.

"L'INCONNUE."

Passim.

There was the usual large crowd of men at the Annual House Dinner on Monday last at the commencement of the Session. Dr. Pye-Smith —who only arrived in town in time to run down to the hospital for the dinner—looked exceedingly well and was in excellent form, and met with a most enthusiastic welcome. Although owing to the exigencies of time speeches were cut very short, Dr. Pye-Smith made a delightful speech, and expressed his pleasure at seeing so many friends, and announced his intention of remaining president of the Students' Club for another year.

There was the usual representative gathering of the Staff at the dinner, and Mr. Cosmo Bonsor also found time to put in an appearance. As Dr. Pye-Smith remarked, however, there were more old faces than new ones, for the first day of the Session is always a day of reunion among the ancients, and meetings of those separated for varying periods always lend an air of good-fellowship and excitement to the evening.

Dr. Wheelton Hind's paper was excellent, though he laboured under the disadvantage of speaking in Egyptian darkness for the first half-hour, owing to the failure of the electric light. Dr. Hind is evidently an enthusiast, and infected his audience with some of his keenness, and brought home to many the great attractions of a subject which has, as Sir Samuel Wilks pointed out, always had an attraction for Guy's men in the past. Of the speeches by the men, Mr. F. E. Walker's deserves great praise. The historic figure of Sir Samuel Wilks, without whom no opening night of the Physical Society would be complete, struck a familiar note to all old stagers, and it is hoped that he will be spared to grace many more such meetings in the future.

Among the exhibits in the Physiological Laboratories afterwards, undoubtedly much the best and most striking were the skiagraphs of normal and pathological conditions shown by Messrs. Kirkman and Shenton. As they intend devoting most of their time to this branch of modern surgery, they could wish no better recommendation than Monday night's exhibit. On the 28th of this month, at a meeting of the Physical Society, the same gentlemen are going to give a demonstration on the recent developments of the X rays and their application to medical subjects.

At a recent meeting of the presidents of the Physical Society, Mr. Targett announced his resignation of the post of chairman, and Dr. A. P. Beddard was elected in his place. Mr. Targett has been connected with the Physical Society for such a long time, that his resignation was received with great regret, but owing to the increase of work and consequent lack of time, it was unavoidable. The Physical Society owes more to Mr. Targett than the present generation probably appreciates, and he has devoted a large portion of a busy man's time to its welfare, and has always had its interests at heart. It is to be hoped that Mr. Targett will not entirely sever his connection with the Physical Society in the future, for his loss will be severely felt.

The dinner on Monday night was excellent, and we hope that it may be but a foretaste of improvement in the immediate future. The chief onus of responsibility lies, we think, with the catering committee. One of these gentlemen, whose name we read in the Blue Book, was elected before June, but was ignorant of the fact that he was on the committee. Evidently he has not been very busy safe-guarding the interests of the members of the club. The other member of the sub-committee does not live in college, and has, obviously, never talked to his colleague on the subject of food. Something is wrong here; either these gentlemen were not informed of their election or they have neglected their duties. In either case a little more careful watching of the dining-hall and its ways in the coming session would be of benefit.

We are requested to call the attention of all Cambridge men, and others, for that matter, who come up to Guy's, that at Cambridge House, 131, Camberwell Road, not far from Guy's, they can obtain excellent board and lodging at an inclusive charge of 30s. a week. Cambridge House is one of the many lay settlements so numerous in South London, and no particular views or opinions are pressed upon the residents, and it is not necessary, unless men like, that they should take any part in the social or ordinary work of the settlement. There are still a few vacancies, and any men will be heartily welcome. For those who have the time there is also much good work to be done in the evening helping in the gymnasium

or giving ambulance lectures. Further particulars can be obtained from the Head, the Rev. W. F. Bailey. We might perhaps also note that the Secretary is Mr. Guy Lushington, son of the former Treasurer, Mr. Edward Lushington.

On Wednesday, the 27th of September, at St. Mary Abbot's, Kensington, the Rev. C. W. McLaughlin, of Newark-on-Trent, was married to Miss Lucy Steele, daughter of the late Dr. Steele, Superintendent of this hospital. The Rev. C. H. Bowden, the former chaplain here, assisted at the ceremony.

We regret to say that among other errors left uncorrected in the last number of the Gazette we announced that Dr. Newton Pitt would go round the Medical wards on Saturdays among other days. All footballers will be glad to hear that Dr. Pitt pleads *not guilty* to any intention of doing such a thing, and his days for going round are Monday, Tuesday, Thursday and Friday.

Several members of the Staff, as well as the Treasurer, were asking on Monday evening if there were ever going to be any Smoking Concerts at Guy's again. At the risk of repetition we would again urge upon the Residents the absolute necessity of holding one at the earliest possible date, and upon all newcomers their bounden duty to declare themselves and their talents as soon as notice is posted. A good Smoking Concert would do us all a lot of good.

We have to thank the *Outlook* of September 30th, for a word on behalf of the medical profession. It says:

With war in South Africa imminent the warnings of Professor Ogston as to the condition of our Medical Services, in his address before the British Medical Association, sound ominously in our ears. The Royal Army Medical Corps, for instance, is short of about 100 officers, and at the last examination, though twenty-eight commissions were offered, only fourteen were conferred. The fact, of course, is that the conditions of the services generally are not such as to attract the best men. Recognition as "gentlemen" has at last been accorded in the case of the Army Corps, but most grudgingly. One of the most striking features of the late Soudan campaign was the low death-rate and superb sanitation; yet not a single medical officer was decorated, nor was the service mentioned in the public vote of thanks. The medical department has also been conspicuously ignored in the campaign against the plague in India; as the *Times of India* says, "the medical man has been carefully kept in the background with his hands tied behind him." The routine work required of medical officers in garrison and times of peace generally is both monotonous and narrow, and their only chance of keeping abreast of the times is by those frequent leaves of absence for study and practice in the large hospitals which the seriously undermanned condition of the service renders it most difficult to secure. Then the facilities and equipments for private study and research afforded by the Government to army surgeons are simply contemptible by comparison with those provided freely by most of the Continental Powers. Even Russia is far ahead of us in this respect. All this is wrong, and should be summarily put right. In the case of the Navy, the Admiralty have wisely determined on reforms in the medical training, but the Army lags behind. We do not want another Crimea breakdown.

What the *Outlook* says about the Army Medical Service is also rather true about the profession in general. There is many a good deed done in secret, and certainly doctors do their share of these with small chance of any material recognition or reward. It is, however, better so than that the profession of medicine should be entirely a commercial affair. The touch of humanity in a doctor's life is the principal attraction to many of the best men, and recognition of the kind bestowed upon the successful grocer or tea merchant would be small honour to the profession.

Weather like the present does not make for a good commencement of the football season. Notwithstanding adverse circumstances, the trial games have been very well attended by freshmen this year, and there is every promise of our football teams keeping up their reputation. Four fifteens have been arranged for on the Rugby side, and the Association players can easily put forward three elevens, so there is no lack of opportunity for good men to make their mark. We would advise all freshmen to read the football notes and advice in the present number, and especially take to heart the notice concerning the lists of teams and of men desirous of playing, which are posted in the Smoking Room.

The Open Scholarship in Science has been won this year by Mr. H. F. Bell Walker and the Open Scholarship in Arts by Mr. F. Wood.

In the scholarship competition for University men, Oxford has again scored this year, in the person of Mr. Blake Odgers, a worthy successor, we believe, to the honours which Mr. H. S. French carried off last year.

Growth of the Large Intestine.

CLINICAL LECTURE BY Mr. DUNN.

July 13th, 1899.

Gentlemen,—I am going to talk to-day about two cases of Growth of the Large Intestine. They illustrate very well the method I usually recommend in the treatment of these cases, and therefore I will just read out the reports.

The first case is that of a man, W. C., aged thirty-six, a waterside labourer, who was admitted into John ward on September 30th, 1897, under the care of Dr. Hale-White, for swelling of the abdomen and great abdominal pain. The family history proved that his mother died of cancer of the abdomen. He has always been well and healthy except for a small urethral abscess which formed six years ago. The present illness appears to date from four years back. Before that time his bowels had acted regularly every day; since then they have been irregular, sometimes not acting for a week, at other times only every other day. His motions were always well formed, and he has never suffered with diarrhœa or passed any blood *per rectum*. For the last four years the patient has noticed a band rising in the abdomen, which, from his description, appears to be a coil of intestine; at the same time he noticed gurgling noises in his abdomen, and experienced severe colicky pains; these were especially marked after indulgence in alcohol.

On September 26th he ate some rabbit and pork for dinner at 2 p.m. Soon afterwards he experienced pain in the abdomen. At 9 p.m. the pain became more severe. The bowels had acted in the morning of this day, but from this time till admission (Sept. 30th) neither motion nor flatus had passed. The abdomen steadily increased in size, and the pain was constant with occasional exacerbations. He has had no vomiting.

On admission.—Apart from the abdominal pain, the patient seems fairly well. The tongue is moist and clean, the temperature is normal, pulse 56, and respiration 20 per minute. The abdomen is uniformly distended, it moves very little with respiration, and some peristalsis is visible, apparently in the small intestines. There is slight tenderness over the abdomen, especially in the left iliac fossa. The percussion note is resonant except over the right iliac region. The abdominal walls are rigid, and there is a feeling of resistance below the right costal margin for one and a half inches, which may possibly be liver. The report does not mention the condition of the rectum on digital palpation, but I fancy it was found to be empty.

I saw the case at 2 p.m. on October 1st, and decided to open the abdomen. The surface was cleaned and shaved in the usual manner, and a median incision was made between the umbilicus and symphysis; the peritoneum was reached and divided, and the great omentum came to hand. This was drawn downwards so that the transverse colon could be investigated; this was found to be empty. The cæcum was next felt for, and found to be greatly distended, and immediately above this a hard mass was discovered, which from palpation appeared to be a growth in the ascending colon. We had to trust to palpation as the mass was so fixed to the posterior abdominal wall, that it could not be brought into view. We decided, under these circumstances, that it would be best to open the cæcum. Accordingly an incision was made in the right inguinal region over the front of the cæcum on to the fingers of the left hand which was pushing the abdominal wall forward from the interior of the peritoneal cavity in this region. This incision was about one and a half inches long. On withdrawing the hand from the peritoneal cavity the cæcum presented at the new incision. A purse-string suture was inserted into the anterior wall of the cæcum and the gut was fixed to the margins of the incision by means of interrupted sutures inserted beyond the purse-string. When thus firmly secured, an opening was made into the cæcum with a knife at the spot surrounded by the purse-string and a Paul's tube was introduced and fixed by tightening the purse-string around it. A large quantity of liquid fæces drained away at once, being conducted into a basin under the table by means of a long piece of indiarubber tubing which had been fixed on to the Paul's tube previous to its insertion. The median incision was then closed by three layers of sutures in the usual way, and dressings were applied. The patient was very well after his return to bed and by 10 p.m. three pints of fluid had drained away through the tube. The tube sloughed out after having been in for nearly four days.

The patient caused us no anxiety at all. He had no trouble beyond a little excoriation of the skin around the artificial anus, due to the irritation of the liquid fæces.

On November 5th a second operation was undertaken for the removal of the growth. After having cleaned the surface of the abdomen as far as possible, and plugged the artificial anus with iodoform gauze, a vertical incision was made in the semilunar line over the site

of the growth which had been located at the previous operation. The peritoneal cavity was opened and the mass exposed, but as it was rather difficult to deliver it through the incision, the opening was prolonged downwards and inwards for about one and a half inches by means of curved scissors. The mass was then delivered through the wound, and the colon was emptied both above and below, and kept empty by means of Lane's clamps. The meso-colon was next transfixed by three or four stout silks, as far as possible from the gut, and securely ligatured; it was then cut through with scissors. It was now discovered that two loops of small intestine were adherent to the mass, one quite slightly which was easily separated by means of the finger, but the other loop firmly attached, and markedly infiltrated by the growth, making it quite clear that this part of the small intestine would have to be sacrificed.

We next packed the wound around with broad strips of iodoform gauze, and divided the colon above and below well clear of the growth, taking out altogether between three and a half to four inches of it. A large—not the largest—Murphy's button was quickly inserted, the bowel was washed with lysol lotion, and, after the clamps had been removed, was returned into the abdominal cavity. The small intestine was treated in a precisely similar manner, except that only one and a half inches were removed, and of course a smaller button was used. The wound was then closed in the usual manner, and the patient was taken back to bed.

He was fed by nutrient enemata for the first twenty-four hours, after which he had a little peptonised milk and barley water by the mouth, about two ounces every two hours. He progressed favourably for the first three days, and passed flatus freely both through the natural and artificial anus. On November 8th, the fourth day, the temperature rose to 102°. The abdomen was more full over the site of the last operation, and there was tenderness and resistance in addition. On the next day two or three stitches were removed, and the edges of the wound separated, which allowed a little pus to escape. The wound was fomented with boric acid lotion. The bowels acted twice naturally. On November 11th the temperature was nearly normal. A little pus could be squeezed out of a small cavity in the wound which seemed quite superficial.

On the 13th the discharge of pus had increased from the wound, and it was gaseous and decidedly fæcal; the temperature had risen again to 101·6°. All nutrient enemata had by this time been discontinued, and the patient was taking farinaceous diet, eggs, milk and beef-tea. An anæsthetic was given, and a probe, on being introduced into the sinus, impinged upon one of the buttons, probably that in the small intestine. A small drainage tube was inserted. On November 20th I explored the sinus again under an anæsthetic, and by very gradual dilatation of the sinus managed to insert the little finger. I then nipped hold of the button with a Spencer Wells forceps by inserting one of the blades into an aperture in the button, and brought it into view; then, by very carefully easing off the soft tissues, it was finally delivered, and proved to be the smaller of the two buttons. After this the fæcal fistula gradually closed. The artificial anus had, of course, been acting the whole time. As nothing had been seen of the larger button, a skiagraph was taken on December 18th. This showed a slight shadow at the upper part of the right iliac bone, but nothing could be felt of the button by inserting the finger in the artificial anus. On the 24th, as the fæcal fistula seemed firmly healed, the artificial anus was temporarily closed by means of a colotomy plug and belt. On the 26th the button was evacuated by the natural anus. For the next three months he remained in the ward and went on well, except that the fæcal fistula would discharge occasionally. It always stopped as soon as the fæces were allowed to flow out of the artificial anus by removing the plug. The plug had been exchanged for an air pad, so as to give the artificial anus a chance of healing. He left on April 6th, and could go for two days without shifting the colotomy pad.

In this case we had to take out two pieces of intestine first of all, large intestine, and then at the same time a bit of the small intestine. So that the patient really had two buttons in—a large button below the artificial anus and a small button above it. He got on very well. The small button caused a little abscess, but it all healed up, so that there was no general peritonitis. We managed to get that out; the other one passed in the usual way. The patient was re-admitted into Lazarus ward in order to have the artificial anus closed. An operation was performed on the 7th, when an elliptical incision was made about half-an-inch distant from the margins of the orifice, and the skin (which was chiefly cicatricial) was reflected towards the orifice, and then turned inwards so as to have the epithelial surface towards the lumen of the tube, and the freshly cut surface exposed. It was kept in this position by

means of half a dozen interrupted sutures put in Lembert-wise. The skin was much undermined distally for about an inch all around the incision, and was brought together and held in position by means of thin quilled sutures, the edges being united by points of interrupted suture. A pad was firmly applied, and the patient was returned to bed. Everything went well for three days, and then a little leakage occurred; this continued, but the anus had been narrowed to a very considerable extent. He shortly afterwards left the hospital, as it was hoped that the aperture would close. The opening was then quite small. I told him to come up if any further trouble resulted, but he has not returned. I had taken his address, and I wrote a post-card to him, but he had moved, so that I cannot say exactly what condition he is in now; but I feel certain, from knowing the man, that he would have come up if there were any trouble resulting from this artificial anus. I feel sure that it must virtually have closed.

The next case was that of Sarah S., married, aged 35, admitted into Mary ward under the care of Dr. Hale White, on February 14th, 1898, suffering from vomiting and abdominal pain. She has been married two years but has no family. Her present illness began two years ago, with symptoms similar to those she now has. The attacks, which last about twelve hours, and during which she has almost constant sickness and great pain, appear every two or three weeks. Her bowels have never been regular, and for the last two years the motions have been getting smaller, and occasionally streaked with blood. Her present attack commenced on February 2nd, with very severe pain and sickness. The bowels have acted on one occasion only during the interval between the onset of the attack and her admission into hospital on the 14th, viz., on February 6th, when a fair sized motion passed.

On admission.—The pulse was 90 and temperature 99°. The tongue is dark, red and furred. There is no blue line on the gums. The abdomen looks full and tense, and periodically a roll of intestine can be seen bulging the abdominal wall. The abdomen feels doughy, and is resonant on percussion. No tumour can be felt.

Patient had a glycerine enema the day after admission, which brought away a little fæculent material. She had a good deal of retching at night, but vomited very little. She was treated by daily enemata, with varying result, but she did not have a bad attack of vomiting till the 21st, when she was sick all day. As it seemed quite evident that the patient was suffering with a chronic intestinal obstruction, I was asked to see her, and decided to explore the abdomen on the 23rd. Accordingly, after due preparation, a median incision about three inches long was made between the umbilicus and symphysis pubis. The peritoneum was opened and several coils of distended small intestine presented. The hand was then introduced, and the transverse colon was brought into view by making traction upon the great omentum; this was found to be distended. On tracking the gut round, an elongated induration about one and a half inches long was discovered in the lowest portion of the descending colon. This was so fixed posteriorly that it could not be brought up into the wound. The empty sigmoid flexure could easily be demonstrated. We now decided to open the transverse colon, forming an artificial anus temporarily, and to remove the growth at a subsequent date. The abdominal wound was enlarged upwards for an inch or two, so that there should be no undue tension upon the transverse colon, and then a loop of that viscus with a portion of the great omentum, which was not very fat, was brought out of the wound. The abdominal incision was then closed from below upwards in the usual way, leaving the topmost inch and a half open, out of which the loop was protruding. A Spencer-Wells forceps was then pushed through the transverse meso-colon, and was retained in position by gripping a sterilized pad with its blades. The loop and omentum were then surrounded with iodoform gauze, and a Paul's tube was tied into the gut by means of a purse-string suture. She progressed favourably after the operation. The Paul's tube separated on the 26th. The artificial anus acted well. On March 15th she was operated upon a second time for the removal of the growth. After adopting the usual precautions an incision was made about four inches long on a slightly higher level than that selected for our surgical colotomy. The peritoneal cavity was opened, and the growth exposed. After separating some adhesions the bowel and growth were brought up to the wound. The bowel was the descending colon. The gut was emptied above and below the growth, and kept so by means of Lane's clamps. The peritoneum, forming the meso-colon, was transfixed by means of an aneurysm needle, was tied in four separate ligatures, and divided by scissors between the gut and the ligatures. The growth was then separated by cutting the bowel across above and below it. One of Murphy's colon buttons was

next introduced, the bowel washed up and returned into the peritoneal cavity. The wound was closed by means of three layers of sutures and dressed in the usual way.

The patient caused us no anxiety, and on April 6th the button was discovered to be lying in the rectum.

The patient left the hospital on April the 15th, and will remain as out-patient for some months in the hope that the colotomy wound will close by itself. In case it does not do so, she will be admitted again for further operation. About four inches of gut was removed. It was quite clear of the growth, except in one small place at the upper part, where the section of the gut was a little thick. However, the sloughing produced by the pressure of the button would quite destroy this.

This patient has been up as an out-patient from time to time. She has got on perfectly well. The temporary artificial anus in the transverse colon has almost closed. All the great omentum and the transverse colon have been perfectly dragged back into the abdominal cavity, through which there is only a small aperture by which the fæces escape. She has been passing fæces regularly by the ordinary way. I saw her a few weeks ago and she was then perfectly well.

Well, now, since this I have operated on another case of the same sort, the patient being a lady down at Northfleet. She had chronic constipation and vomiting; her abdomen was distended, and despite purgatives she could get no action of the bowels. I went down to see her and I opened the abdomen in the middle line. I would say that it is always better to go well up to the umbilicus. I go rather above it than below. Next put your hand into the abdomen and find the great omentum. That will lead you to the transverse colon attached to its under surface. The transverse colon will probably be distended, as it was in this case, and then you will know the obstruction is lower. And then you pass your hand down towards the splenic flexure and descending colon and try to make out the growth. It is rather a difficult thing to detect the growth because the intestines are naturally all distended. If you cannot trace the descending colon, feel for the sigmoid flexure; you can generally find out that and it may be empty, if so, you will be able to trace the collapsed part of the intestine up until you encounter the growth. Before doing anything be quite sure where this growth is, because you are going to remove it at a later date.

When you have definitely located the growth then proceed to make a temporary artificial anus, as was done in this last-mentioned case, at some convenient spot above. Usually open the transverse colon if the growth is below the splenic flexure, or one may have to make a second incision, as in the first case I spoke of, where the cæcum had to be opened. It is quite a simple process. You pull out a loop of transverse colon and lift the omentum up so as to expose the under surface of the gut, then tuck the omentum into the abdominal cavity at the upper angle of the wound and transfix the transverse meso-colon by some blunt instrument, such as a Spencer-Wells forceps. Through the hole thus made you can place a glass rod, or you may leave the forceps in situ, and just clip between its blades a small sterilized swab. You then narrow the wound to one and a half inches by three rows of suturing. The forceps will keep the gut well up. If the colon is greatly distended open it at once and put in a Paul's tube. If only moderately distended you can leave it three or four days before opening it. By these means you have entirely prevented any fæculent material passing the artificial anus. If all goes well in about three weeks you can remove the growth. It is always better to attack it as soon as possible in case it may infiltrate another portion of intestine, as happened in the first case I read. In this last case we removed the growth in the usual way, and here is the portion (produced). The case was rather a difficult one because the patient was very stout. However, her doctor writes that she is doing very well indeed. We do not expect the button to appear yet, it will probably be passed in something like ten days' time.

When you are going to remove the growth you proceed in the following way:—You cover up the artificial anus carefully with sterilised pads, and then thoroughly clean the abdomen. You make a vertical incision over the site of the growth. After having opened the peritoneum, you deliver the mass through the wound, and then clamp the gut above and below it by means of some form of intestinal clamp; that devised by Mr. Lane is very convenient. You next tie the meso-colon corresponding to that portion of the intestine which you intend to remove by transfixing it with an aneurysm needle in three or four places, and ligaturing it in as many sections. It is better to tie the meso-colon as far away as possible from its attachment to the colon, so as to include any glands that may be affected, and to make sure of getting well beyond the limits of the growth;

then divide the meso colon between the ligatures and the gut, and pack underneath and all around the exposed mass; then cut the intestine across transversely with scissors, so as to be well wide of the growth, and take the separated mass away. You then put in a Murphy's button, and draw together the cleft in the meso-colon by a point or two of interrupted sutures, and after having thoroughly cleansed the part extended with some antiseptic lotion, and removed your packing, return it, and close the abdominal wound in the usual manner.

Now, in doing transverse colotomy, of course we hope it will only be a temporary artificial anus, but still it will do very well for a permanent one. A lady was operated upon three years ago next September in the South of London. She was a young married lady, and had all the signs of chronic obstruction, which had become rather acute. Her abdomen was greatly distended, and she was so ill that we had to operate straight away. It was rather under difficulties that we did so. There was one general practitioner giving the anæsthetic, there was a nurse not very well skilled, and there was another general practitioner who was going to help me, and the dresser. The nurse fainted as soon as I had opened the abdomen, and the other medical gentleman who was to have assisted me had to attend to her instead. The peritoneal cavity was full of blood-stained fluid, and I had to do the operation rather quickly, so that I really could not find out exactly where the growth was. So I opened the transverse colon in the way described. The patient did perfectly well, and the artificial anus became permanent. She became pregnant, and then her family practitioner came up and said, "Mrs. So-and-So has become pregnant, but what about the colotomy wound when the uterus enlarges?" I said, "I dare say it will accommodate itself." The child was delivered, and everything went on all right—so well, indeed that she did not come up to see me at all. I heard nothing more of her till the other day, and then she came up with a constant desire to void the contents of her bowels the natural way without success; the artificial anus had acted perfectly; she could entirely control all evacuation by means of a little plug. When I put my hand on the abdomen, the growth was fixed right down towards the sigmoid flexure, and had no doubt greatly infiltrated the posterior wall, together with numerous glands. So large was it that I said I thought it would not be wise to attempt its removal. You remember it was three years ago in September that she was operated upon, and so you see that these growths are very slow in their progress. I operated upon another case of transverse colotomy down at Woolwich, and I heard four years afterwards that the patient, a lady, was quite well, and the artificial anus was acting perfectly. It is sometimes stated that an artificial anus in this position causes annoyance by means of the exhalations, but no unpleasantness of the kind is felt if a suitable belt be worn. There is no disadvantage at all that I know of in opening the transverse colon, and I think that position is certainly a good one if you want to make a temporary anus.

Sometimes when you expose the transverse colon, you find that the growth is in the transverse colon itself. It is very trying to know what to do in a case of that kind. You get one growth out, and then you will very often find that there are other growths in the peritoneum. I usually take the transverse colon out of the abdominal cavity with the growth, and transfix it there with a Spencer-Wells forceps, and in a few days I remove the whole mass. In this case (here) I left a permanent artificial anus at the transverse colon.

If asked what is the nature of these growths and when they usually occur, you will say that they are columnar-celled carcinomata, and they are not very rapid in growth, and they occur in young as well as elderly people. The text-books always tell you that the lower you get down in the large intestine the more frequently is the growth to be found. That is true, I suppose. But many people say that it never goes above the splenic flexure. I myself have been remarkably fortunate, or unfortunate rather, in finding cases with the growth high up. I remember that Dr. Goodhart, not many months ago, asked me to see two cases for him. I made a median incision, instead of making an incision for an ordinary inguinal colotomy. In both of these cases the transverse colon was collapsed, and in both I had to make another incision over the cæcum, which I opened. In the first case recorded the growth was just in the ascending colon, you see. I have often found it there, and in the hepatic flexure, sometimes in the transverse colon. I prefer to explore from a median incision than to perform an inguinal colotomy. Formerly they used to do lumbar colotomy; we do inguinal now. Inguinal colotomy is not the very best operation to perform because when you come down on the sigmoid flexure it very likely will be empty; that is to

say, the growth is above. Well, then, what are you to do? I recollect coming across a case of this sort, and I was asked to open the colon—it was the case of an old lady—in the inguinal region. I cut down in the usual manner, and came on an empty sigmoid. It is very difficult to explore the abdomen through an inguinal colotomy wound, but I put in my hand and pulled out the great omentum, and then I brought out the transverse colon which was distended, and opened it in the inguinal region. But I am quite sure that you will feel your way much better if you do a median incision; I think it is much better to open the abdomen in the middle line, pull down the transverse colon by means of the great omentum, and then you will know exactly where you are. Then you make an artificial anus temporarily, and remove the growth at a subsequent date.

The artificial anus sometimes requires to be closed, but I think it is rather a good thing to keep it open, because, as the button comes away, it may leave a fibrous stricture which will contract, and so then you will very likely have to open the artificial anus again if it has been closed.

Hospital News.

CLASSIFIED LIST OF CASES.

"Clinical."

John	2.	Spasmodic bronchitis.
	3.	? Cerebral tumour.
	4.	Gall stones.
	5.	Typhoid. Abscesses.
	6.	Pericarditis.
	7.	Mediastinal tumour.
	10.	? Splenic anæmia.
	11.	Pleuritic effusion.
	12.	Appendicular abscess.
	13.	Typhoid.
	14.	Aphasia.
	15.	Acute nephritis.
Miriam	17.	Hydrochloric acid poisoning.
	19.	Typhoid.
	20.	Typhoid.
	22.	Acute rheumatism.
	23.	Appendicular abscess.
	24.	Hæmaturia.
	27.	Mitral regurgitation and stenosis.
	28.	Hemiplegia. Aphasia.
	29.	Gastric ulcer.
	30.	Appendicular abscess.

De Gustibus.

A Tragedy.

It was not a cheap umbrella, but I own that it was an old one. When I look back on its early days I feel I should be doing it an injustice if I said I had never really liked it; later events may perhaps have altered my opinion of its character—but still, when it was new and sleek and slim, I admit I had a feeling of pleasure in its society, and something akin to pride when on a fine Spring morning I walked out in the delightful assurance that it *couldn't* rain, and glanced down on the piquant turn of the handle, and coquettish little band of silver that encircled its neck.

But these days are long, long passed, and somehow, as it grew older, I didn't take to my umbrella as an old friend. It is true that I treated it as such, taking it out with me on dark, rainy days, when I didn't like to take out my newer companion. Forgetting it for months in the summer, leaving it about in dusty corners of the hat-stand, and never rolling it up when I put it away. But, as I say, I never seemed to feel under any obligation to it, though it had kept the rain off me in many a stormy day and squally night. But perhaps I shouldn't feel so bitter against it now that it has gone, had it not been for the events which immediately preceded our parting.

"Don't forget your umbrella!" said my sister, who was staying with us, when I started out on that fatal day in November. The words, though it didn't strike me at the time, were an omen. It was far too bad an afternoon for anything but the old umbrella. As I alighted from a bus at Regent Circus and put it up, the wind rattled through the wire frame, the rain began pattering on to the alpaca ("quantum mutatus"—I had had it covered with alpaca last time!) and poured off the little nobs in a constant stream almost at once. I had several commissions to execute in Regent Street, and while I was busy in various shops, the storm increased. As I left the last it was blowing a regular hurricane, the wind seemed to strike one from all sides at once, and though the rain had somewhat decreased, the squall seemed worse than ever. I looked at my umbrella, and then at the sky. Well, it was only an old one, I thought, adding mentally that it didn't much matter if it were blown inside out. I little knew my fate!

I put up the umbrella.

Round a street corner came the wind, carrying before it the hats, parcels and various excrescences of several unfortunate individuals. I smiled. People in distress looked funny to me, *then*. Suddenly changing, the wind struck me hard in the back of the neck. I staggered forward and tried to turn my umbrella against it. It was too late. In a moment there was a rattling of wires, and the umbrella shivered, and seemed to double up in my hand. I turned, facing the wind, and looked at the umbrella. It was a total wreck. Do what I would I could not get that umbrella to fold back again; with a stubborn determination, which I can but attribute to some original

fault of character, it refused to fold up. It lay passive in my hands, an elongated, shapeless mass of wires, wood and alpaca.

What was I to do with it? I had an important appointment in an hour or so, and I felt that the presence of an umbrella in this condition would prejudice me in the eyes of the most impartial observer. I must get rid of it before then.

I first thought I would buy a new one, but, unfortunately, I had spent nearly all the money I had on me, and there wasn't time to go home for more. Should I take a cab? No! That would be extravagant, and, besides, I could easily get rid of the wreckage in some other way. A bright idea struck me—I would give it to a sandwich man; he might possibly be glad of it and turn it to some account.

A miserable specimen of the class alluded to approached me. I went up to him intending to say "would you like an umbrella?" but in the excitement and hurry of the moment, I said, "Would you like a—a sandwich?"

"'Oo'er yer getting at?" he asked in a hard, surly voice. I felt after this that further negociations were useless. I would try another. But there wasn't another. They had vanished—all save this one—and were sheltering themselves in unknown alleys from the storm.

Well, why not leave it in the road! That was at any rate easy enough. I didn't quite like to deposit it in Regent Street, *coram publico*, as it were; some one I knew might see me and draw deductions as to my mental condition. So I turned down into Swallow Street, and while pretending to look in at a shop window, propped the wreckage as well as I could against the door-post and then walked hurriedly on.

"Hi, Mister!" shouted a voice behind me, "you've left yer brolly!"

I couldn't help turning round, and beheld a rough-looking man grasping the wreckage and waving it at me. I almost asked him to keep it for my sake. But after the sandwich man's rebuff I dared not. I meekly said "thank you," and took it."

"Drink yer 'elth, sir!" said the man.

It was too bad! However, there weren't many people about, a broken umbrella is not a good weapon of defence and the man looked at me ominously. I hadn't got any coppers. I gave him sixpence, and the wreckage was still with me.

Could I drop it down a drain? No! In its slimmest days it wouldn't have gone between the bars, and now it was obviously impossible. It was equally impossible, apparently, just to leave it in the street. Another bright idea, however, struck me—Don't people often lose umbrellas in shops? I would go and have tea somewhere and *forget the wreckage!*

I walked into one of the tea shops in Piccadilly. A polite commissionaire offered to relieve me of the wreckage (which had to be grasped about the middle of its extended length) remarking that it was a stormy evening. I refused, as I knew he wouldn't let me forget it, and he was too splendid an individual for me to ask him to keep it.

I spent one of my few remaining coins on the tea—the wreck lay under my seat, and under that of two elderly ladies at the next little table. I don't know quite what I ate or drank—I was becoming worried and nervous about the thing, and felt I was eating with a murdered corpse under the table. I couldn't forget it was there. As soon as I decently could, I got my bill, paid it hurriedly at the desk, and ran out. Some cold drops of rain on the top of my head (I am getting rather bald) stayed my wild career. *I had left my hat behind as well.*

I went sorrowfully back. The splendid commissionaire solemnly handed me my hat—*and the wreckage.* By this time I was quite sure that the wreckage was doing it on purpose. There was a desperate and sordid air of vice about the once pretty handle; the wires, with their little nobs (once gilded) bristled with a horrid determination not to leave me or be left by me. Though broken backed, it was still stubborn of purpose.

I had now really very little cash left on me, so I must necessarily be careful what I did. I thought of buying an evening paper or two, and wrapping up the wreckage in them, but, on second thoughts, this would only seem to add to my difficulties—it would be, of course, mistaken for some infernal machine and I might get into trouble. No! I had it! I would take a 'bus, and leave it there. One passed me, going to Westminster. I jumped on hurriedly, and with difficulty reached the top, owing to the wires which got between my knees and caught in my coat tails and the rail of the steps. I longed to drop it overboard, but knew it would be useless.

At Westminster Bridge I got down. There was a block, and the bus remained standing at the corner of Parliament Street.

"This your parcel, mister?" said the conductor, who had followed me down. The wreckage looked at me maliciously, as who should say, "You know you daren't disown me!" It was weak of me, I admit, but my nerves were unstrung. I took it from the man.

Scarcely knowing what I did I walked rapidly on to the bridge. Why not throw it into the river? No sooner thought than done. I leant over the parapet and reaching out as far as I could dropped the thing down into the semi-darkness. At that moment a penny steamer shot out from the arch beneath, and as I turned to flee a heavy hand was laid on my shoulder and a gruff voice sounded in my ear.

"At your old games, are you? Well, never mind, I've got yer *this* time, so come along!"

It was a minion of the law.

It was useless for me to assure him I had an appointment in the lobby of the House of Commons—foolishly enough in the first excitement of the moment I had denied dropping the wreckage over. "Larst time it was stones I see yer throwin'," said the constable, "this time, Gorblimy, I don't know what it was, but it was big enough to swamp one of them there boats."

Further details of the proceedings are perhaps unnecessary. But I may mention that the total money cost to me (leaving out moral and intellectual damage) of getting rid of that umbrella, amounted to £2 14s. 8d.

B.

Nursing News.

Matron's Office.

The following appointments were made by the House Committee on October 5th. Nurse Tippetts, Nurse Willes, and Nurse Holman to be Probationary Sisters. Nurse Tippetts to be Night Sister on October 15th. Sister Annette to be Surgery Sister on November 1st. Nurse Willes to be Sister of Out-Patients on November 1st. Nurse Holman to be Night Sister on November 1st. Probationer F. Brown has been made Head Nurse and was appointed Junior Dormitory Mistress on September 30th.

Nurse C. Davies left the hospital on October 5th, after three years' service, to take up her new appointment of Sister at the Camberwell Infirmary.

Nurse Atkinson left the hospital on October 5th to enter on her duties at the Private Nursing Institution.

Nurse March left here on October 6th to take a holiday, and then to begin her work at a Private Nursing Institution in Cambridge, to which she has recently been appointed.

The Surgical Examination was held on Thursday, September 28th; there were eighty entries and only six failures. The maximum marks were 200, and those who came out highest on the list were:—1st, Hilda Minshall, 198; 2nd, Ethel Howlett, 195, Mabel Vivian, 195; 3rd, Katharine Kane, 190, Ellen Dawson, 190.

Result of the Probationers' Surgical Examination:—B. Allcock, A. Allcock, Anness, Backett, Baynes Reed, Ball, Beales, Bell, Bennett, Bible, Blayney, Bolton, Boyle, Bryan, Cameron, Chawner, H. Clark, S. Clark, Coleclough, B. Collins, Connolly, Corder, E. Creasey, M. Creasey, A. Davis, Dawson, Densham, Denyer, L. Evans, Faulkner, Ferrier, Field, Gale, Gatward, Gibbins, Harradine, E. Hayward, S. Hayward, Heygate, Howlett, S. Hughes, Hutton, E. Jones, R. Johnson, Kane, Layton, Lindon, Lord, Lord, Lowenthal, Macnaughton, Micklethwaite, Minshall, Mombert, Morgan, Popple, M. Ray, H. Reeve, Robertson, Spalding, Stanyon, Seville, M. Sutton, Tartt, Tilley, A. Thompson, A. E. Thompson, E. M. Thompson, Vivian, Wallis, Weatherley, Weller, Whittingham.

The Clubs are becoming active and preparing for their winter session. Notice of their proceedings will be found in another column.

In reply to an enquiry made by the Matron, the following letter has been received from the War Office:—

War Office,
London, S.W.,
September 26th, 1899.

Madam,

I am directed by the Secretary of State for War to acknowledge the receipt of your letter of the 22nd inst., and to acquaint you in reply that it is not anticipated that the services of any nurses, other than those of the Army Nursing Service or Army Nursing Service Reserve, will, under any circumstances, be required.

I am, Madam,
Your obedient Servant,
(Signed) J. JAMESON, D.G.

The Matron,
Guy's Hospital, S.E.

A Library for Nurses.

A very long felt want among the nursing staff of the hospital is about to be supplied in the "Guy's Nurses' Library," and it is hoped that the early part of next month will see it in working order.

Hitherto, beyond a few volumes of magazines, there have been absolutely no suitable books at the disposal of the nursing staff.

The use of the College library for some time past has, of course, been much appreciated by the nurses, for without it we should have been badly off indeed.

To give a rough sketch of the plan on which the library is to be worked:—Each member is to pay a small yearly subscription, and on joining is giving a volume—not necessarily new. As there are already 150 members, we start with a fair number of books; as a matter of fact many are giving more than one volume, and several outside friends are taking a kindly interest in the scheme and have promised us books, which of course will be most acceptable.

A committee has been elected to select the books, so that the danger of getting duplicates is guarded against.

It is hoped the library will prove a success. The catalogue includes, besides the fiction of the hour, travels, biographies, and general literature, and last, but not least, a good selection of works, medical, surgical, and nursing; so the committee have done their best to suit all tastes.

L. M. T., *Hon. Sec.*

Papers by Guy's Men.

Somatose and Meat Extracts. By Thomas Stevenson, M.D., F.R.C.P. Lond., and Arthur P. Luff, M.D., F.R.C.P., Lond.—*Lancet*, September 30th.

With Mr. Howse in the Wards of Guy's Hospital.—*Clinical Journal*, 27th September.

The Channels of Tubercular Infection in Childhood. By George F. Still, M.A., M.D., M.R.C.P.—*Ibid.*

The Nurses' Choral Society.

A meeting of the Choral Society was held in the Matron's house on Wednesday evening last. The following business was transacted:—Sister Christine resigned the post of secretary to the Club, and Nurse Haughton and Nurse Daniells were appointed co-secretaries in her place. Sister Esther remains treasurer. The committee remains the same as last year with the exception of two new members—Nurse Helen Newton and Nurse Bowen.

It is hoped that the practices will begin this week, and the Matron has kindly consented, as usual, to lend her drawing-room for that purpose. B. C. O.

Metropolitan Asylums Board.

FEVER INSTRUCTION.

NOTICE TO STUDENTS.

A course of instruction in the diagnosis and treatment of fevers will be held at each of the undermentioned hospitals on Tuesdays and Fridays (except at the Brook Hospital) at the hour stated below, commencing Tuesday, 3rd October, 1899.

Eastern Hospital, The Grove, Homerton, N.E., at 12.15 p.m. E. W. Goodall, M.D., Medical Superintendent.

North-Western Hospital, Lawn Road, Hampstead, N.W., at 12.15 p.m. W. Gayton, M.D., Medical Superintendent.

Western Hospital, Seagrave Road, Fulham, S.W., at 12.15 p.m. R. M. Bruce, M.R.C.S., Medical Superintendent.

Brook Hospital. Shooters Hill, Kent, at 2.30 p.m. J. MacCombie, M.D., Medical Superintendent. (N.B.—The class at this hospital will be held on Mondays and Thursdays, commencing October 2nd.)

Park Hospital, Hither Green, S.E., at 2 p.m. R. A. Birdwood, M.D., Medical Superintendent.

South-Eastern Hospital, Hatfield Street, New Cross, S.E., at 2.30 p.m. F. M. Turner, M.D., Medical Superintendent.

*South-Western Hospital, Landor Road, Stockwell, S.W., at 2 p.m. W. J. J. Stewart, M.D., Acting Medical Superintendent.

Fountain Hospital, Grove Road, Lower Tooting, S.W., at 2.15 p.m. C. E. Matthews, M.D., Medical Superintendent.

The classes at the hospital marked * are full.

The next course will commence in January, 1900.

N.B.—Students desiring to attend a course of instruction must, *before* attending at the hospital, bring (between 11 a.m. and 4 p.m., Saturdays 11 a.m. and 12 noon) or *send by post* to—

The Clerk to the Metropolitan Asylums Board, Norfolk House, Norfolk Street, Strand, W.C.

(1) Authority from the Dean of the Medical School.

(2) Fee—£3 3s. for two months' course, or £4 4s. for three months' course. Cheques to be made payable to—"The Metropolitan Asylums Board."

*** The student must *definitely* ascertain *before* taking out his course whether he requires a *two* or a *three* months' course. In the event of his taking out a three months' course, the extra £1 1s. will not, under any circumstances be refunded to him.

(3) Full name and address, and name of medical school. (N.B.—The name must be in full, and must be distinctly written.)

(4) A list of the above hospitals, arranged in the order in which the student would prefer to attend, in case the classes at any of the hospitals should be already full. At least two names should always be given.

By order, T. DUNCOMBE MANN,
Clerk to the Board.

Sport.

Rugby Football.

The season 1899–1900 begins in earnest for the Hospital to-day, as we are putting four fifteens in the field, which should do themselves and their club credit, if only they will become imbued with the keenness of their respective captains. The season, too, opens not inauspiciously; we hold the Cup, and must from the beginning make up our minds to continue to do so. It is true we are without some sterling players, as Ransford, Ayre-Smith, Hilton, and that prolific try-getter Rae are out of their year, while, for the present, at any rate, we shall be without the services of M. C. Wetherell, T. P. Thomas, P. Manser and K. V. Trubshaw, all of whom should, however, be available for the cup-ties.

True, too, there are among our recruits none with great reputations, but there is some very useful material among the freshmen who turned out well for the trial games, and if they cannot all get into the first fifteen, they will, we feel sure, support their club with that loyalty and *esprit de corps* which has ever marked the true Guy's man in the Rugger field.

Games were played last Saturday and Wednesday respectively, and despite the unfavourable weather there was a good turn out on each occasion, and fairly good football was played. Among the freshmen playing, Harrison, at full-back, though not up to Ransford's form, showed a capacity for being in the right place, and on Wednesday dropped a good goal; he will, with the added experience of a year or so, creditably fill the position. Morgan and Brown, though both on the light side, showed promise, and Anderson, who played in the junior teams last season, has come on a lot, and should turn out a useful scrummager. Wyatt, a half-back from

Lees School, should prove a useful acquisition, and altogether, though none were brilliant, there were several among the new arrivals who will prove welcome additions to the various teams.

We wish to call the attention of all who desire to play during the season to the lists posted in the Smoking Room, and trust that a large number of active members will add their names thereto, as by so doing they will considerably lighten the labours of the committee and captains of the various fifteens.

The new jersey will now be worn by all Rugby players, and can, as heretofore, be obtained either from Messrs. Benetfink of Cheapside, or Lewin of London Bridge.

In conclusion we call upon all players, old and new, to do their utmost for the credit of their club and hospital, and wish ourselves a successful season and a renewal of the mortgage which we hold on the Inter-Hospital Cup. F. G. GIBSON, Hon. Sec.

Association Football.

A Trial Game was played at Honor Oak Park on Wednesday last. The weather was very bad, and anything like combination was pretty well impossible, owing to the slippery condition of both ground and ball. The game, however, was fast at times. H. Barber and T. A. Chignell were the pick of the freshmen. Barber played a dashing game and scored three goals, two of which were well earned. Chignell was inclined to be slow at times, but was good when he made the effort. We were very pleased to see so many freshmen turn out, and hope more will do so in the other trial games, so that all may be seen.

On the whole, the team should be able to hold its own in any match this year, and if the men chosen to represent the team turn out regularly, it will do so.

We have been unfortunate in having several teams scratch or alter their dates after they had once been fixed. This prevented all the fixtures appearing on the card.

From the Gazette's Special Pathologist.

NOTICES.

E. E. M., Newport.—This specimen consists entirely of pus and blood, with which are some apparently normal cells from the mucous membrane of the large bowel. No cell-clumps suggesting malignant growth were found.

H. V. H., Wanstead.—Reaction acid, sp. gr. 1022. Albumen, a small amount. Blood, a few discs. Sugar absent. Microscopical examination.—The centrifugalized deposit contains a fair number of hyaline casts, to some of which one or two tubal cells are adherent. There are a very few tubal cells free in the deposit, and also a few red blood discs.

PATHOLOGIST.

Appointments.

DENTAL APPOINTMENTS.

The following appointments have been made by the Treasurer upon the recommendation of the Dental Council:—

Assistant Dental House Surgeons (for three months from the 1st October, 1899).—Messrs. H. N. Hillier, J. Bennett.

Demonstrators in the Conservation Room (for six months from the 1st October, 1899).—Messrs. G. W. Ray, E. W. Corfe, T. Walkington; (for three months from October 1st, 1899), Mr. S. L. Prall.

CIVIL.

Armer, A., M.B. Lond., L.R.C.P., M.R.C.S., has been appointed Junior House-Surgeon to the Southdown Road Workhouse by the Toxteth Board of Guardians.

Spon, H. J., L.R.C.P. Lond., M.R.C.S., D.P.H. Cantab., has been appointed Medical Officer to the Borough Market Trust, *vice* J. Herron, M.D.

NAVAL.

Surgeon Gerald T. S. Sichel, F.R.C.S., R.N., has been appointed to Haslar Hospital; Surgeon Alexander G. Wildey to the *Alexandra;* Surgeon Charles R. Nicholson to the *Wildfire*, and Surgeon W. Nourse to the *Pembroke*.

An examination for some Appointments in Her Majesty's Indian Medical Service will be held in London on February next.

Births.

FULTON.—On September 24th, at The Bungalow, Lee-on-the-Solent, Hants, the wife of Henry Fulton, M.D., of a son.

MUMFORD.—On September 18th, at Bartlett's Passage, Holborn Circus, E.C., the wife of Wilfred George Mumford, L.R.C.P. Lond., M.R.C.S., of a son.

SCOTT.—On September 13th, at Surbiton, the wife of W. Jerman Scott, M.B., B.S., of Windsor, of a son.

Marriages.

McLAUGHLIN—STEELE.—On September 27th, at St. Mary Abbot's, Kensington, by the Rev. J. Bowden, formerly chaplain of Guy's Hospital, and the Rev. T. H. Gilbert, Church of the Ascension, Victoria Docks, the Rev. Charles Walter McLaughlin, son of Frederick McLaughlin, I.C.S., to Lucy, eldest daughter of the late John Charles Steele, M.D., of Guy's Hospital.

STONER—HALL.—On September 26th, at the Parish Church, Brighton, Harold Stoner, M.R.C.S., L.R.C.P., L.D.S. Eng., of Regency Square, Brighton, to Ethel Mary, second daughter of Edwin Penfold Hall, of Grand Parade, Brighton.

Ed.—H. L. E.

Contents.

	PAGE
On Fracture of Patella: Clinical Lecture by Mr. Davies-Colley	433–438
Hospital News	439–441
Notes from Corea	441–442
Nursing Notes	442
Passim	443–445
Notes of Introductory Lecture to Dental Students: By Mr. W. A. Maggs	445–446
Notice	446
In Lighter Vein	447
Papers by Guy's Men	447
Mr. W. C. C. Pakes	448
Correspondence: The Debating Society; Smoking in the Surgery	448
Guy's Hospital Students' Glee Club	448
From the Gazette's Special Pathologist	448
Illustration	449
Sport: Rugby Football—Guy's v. Kensington; Guy's v. Lennox; Guy's v. Cambridge; Guy's 2nd v. Lennox; Guy's 3rd v. St. Paul's School 2nd; Guy's 4th v. Park House "C"; Guy's 4th v. Old Alleynians 3rd. Association Football—Guy's v. Old Harrovians; Guy's v. Christ Church, Finchley	450–452
Appointments	452
Reviews	452

Calendar of Coming Events.

October, 1899.

Sat. 21.—1 p.m., Clinical lecture by Dr. Pitt.
Messrs. Howse and Jacobson's take-in; Drs., H. G. Rashleigh and L. Pern; Cl., R. C. Mullins.
G.H.R.F.C., I.—Old Leysians, away.
II.—Old Alleynians, home.
III.—Surbiton "A," away.
IV.—Mortlake St. Mary's, away.
G.H.A.F.C., I.—Godalming, away.
II.—L.C.C., home.

Wed. 25.—1.15 p.m., Clinical lecture by Mr. Davies-Colley.
G.H.R.F.C., II.—St. Thomas's Hospital, away.
G.H.A.F.C., II.—R.M.A., away.

Thur. 26.—Messrs. Davies-Colley and Symond's take-in; Drs., S. Roper and G. T. Willan; Cl., E. Cohen.

Sat. 28.—1 p.m., Clinical lecture by Dr. Pitt.
G.H.P.P.S.—Paper.
G.H.R.F.C., I.—Cardiff, away.
II.—Beckenham, away.
III.—Beckenham "A," home.
IV.—Catford Bridge IV., away.
G.H.A.F.C., II.—Eversleigh, away.
Last day for applying to Registrar for Form of Entry for M.D. and M.S. Lond.

Mon. 30.—Final M.B. Lond. Exam. begins.

November.

Wed. 1.—1.15 p.m., Clinical lecture by Mr. Davies-Colley.
G.H.A.F.C., I.—Hastings, away.

Thur. 2.—Messrs. Lucas and Lane's take-in; Cl., J. F. Northcott.
G.H.C.U.—Special meeting.

Sat. 4.—1 p.m., Clinical lecture by Dr. Pitt.
G.H.R.F.C., I.—Rosslyn Park, away.
II.—Rosslyn Park, home.
III.—Tonbridge Sch. 2nd, away.
IV.—Lewisham "A," away.
G.H.A.F.C., I.—Reigate Priory, away.
II.—Furzedown Park, home.

Guy's Hospital Gazette,

OCTOBER 21, 1899.

On Fracture of Patella.

CLINICAL LECTURE BY MR. DAVIES-COLLEY.

October 4th, 1899.

Gentlemen,—I propose to-day to take for the subject of my lecture a rather common kind of fracture—Fracture of the Patella. I find, while talking to men in the wards and also in the examination hall, that there is a good deal of haziness with respect to certain points in the diagnosis and treatment of this particular form of fracture, and I also find that men are so dazzled, I suppose, by the triumphs of aseptic and antiseptic surgery, that they seem to think there is only one kind of treatment possible for it, and that is, to cut down upon it and wire it. They forget that if the surgeon or any of his assistants make some little mistake and allow septic material to get in, you may get acute inflammation of the knee-joint, in which case you are very fortunate if the patient recovers with a stiff knee. Such an accident may necessitate amputation of the limb, and I have had one case in which an old man of sixty-four, whose patella was wired, died from a small septic abscess produced as a result of this operation.

But in a good number of cases, as I shall show you, it is not at all necessary or desirable to perform this rather severe operation. This year I have had under my care five cases of recent fracture of the patella. In three of these cases I have wired the patella, and they have all got quite well. In two of the cases that operation did not seem to me necessary, and the patients went out well in a comparatively short time.

The first case which I have to bring before you is that of a lad aged eighteen, a carman, who was admitted for fracture of the patella on March 21st of this year. About five o'clock on that same evening he was driving, when his horse stumbled. This pulled him off his seat, and he fell to the ground on to his left knee, a distance of about six feet. He was able to scramble to his seat again and drive to the hospital. On admission, his left knee was much swollen and bruised. The knee gave him much pain, and it was found that his patella was fractured transversely. The two fragments were about half-an-inch apart, but could be

brought together, and crepitus obtained. On measurement, his left knee was one and a half inches larger than the right. He was put up in a plaster of Paris splint, and he was able to go out on the 10th of April, three weeks after admission.

The subsequent history I take from my own notes. On the 2nd of June, two months afterwards, he could bend his knee twenty degrees, on the 16th thirty degrees, and on the 29th of last month he could bend his knee through one hundred and ten to one hundred and twenty degrees, and no trace of the fracture could be felt. There was some creaking in movement, due perhaps to osteo-arthritic changes produced as a result of the injury.

Fracture of the patella may be transverse, longitudinal or oblique; it is sometimes comminuted, and occasionally a fracture starting from one point radiates in various directions, and is called starred.

You may be asked, "Is fracture of the patella into the knee-joint?" As a matter of fact it is nearly always into the knee-joint, the reason being that the only structure which separates the patella from the joint is a layer of cartilage. If the bone is broken, in all probability the cartilage will be torn through at the same time. The only exceptions are at the lower and upper ends of the bone. In the lower end there is a little space where, near the apex of the patella, a little fat behind the ligamentum patellæ may separate the fracture from the synovial membrane lining this part of the joint. Sometimes, also, when a person ruptures his quadriceps tendon, a little chip of bone comes off with it without affecting the joint cavity.

Then as to the cause of these fractures. They may result from direct violence such as a fall or blow on the front of the knee; or, again, from indirect violence, which is usually due to a strong and sudden contraction of the quadriceps muscle. In various ways you may get this. I had a patient, aged thirty-four, about two years ago under my care. He was jumping over a barrier at a circus, three and a half feet high; as he sprang both his patellæ gave way, and down he fell upon the ground on the wrong side of the barrier. Or, as it often happens to a person coming downstairs, he thinks he has got to the bottom, but unexpectedly goes down another step, and a sudden stress comes on the quadriceps of the bent knee which snaps the patella.

In such a case the centre of the patella is resting on the bone, while the upper part of the posterior surface and the lower part are not supported by the bone. If the knee were straight, the pull of the quadriceps would come along the axis of the patella, and I think no force that the quadriceps could exert would be sufficient to snap it across. But the patella is caught by the force at a somewhat acute angle with its axis, and when that is the case the patella is much in the same condition as this rod when I am pulling both ends of it, while the middle rests against my knee. Being unsupported at the upper and lower part of its posterior surface, it gives way usually just below its middle part.

Then a very frequent question put to students is: Which is the more serious—to have a fracture of the patella by direct or by indirect violence? Of course you can easily see that if a person has a fracture by direct violence on the knee there is likely to be a great deal of bruising of the soft parts, and, possibly, of the delicate structures in the injured joint. But much the more serious injury is a fracture by indirect violence, and the reason is this: All round the patella there is a great expansion of fibrous tissue. First there is the continuation downward of the fascia lata, and beneath there is the expansion of fibrous tissue derived from the quadriceps tendon at the sides and over the front of the patella. Now, in a fracture by direct violence, the probability is that the injury to this fibrous tissue is very small; even if it is a transverse fracture the probability is that there will be only very little, if any, tearing of this fibrous tissue which lies in front and at the sides of the patella. But supposing it happens to be a fracture by indirect violence, if the force applied is sufficient to tear through the bone, it is almost certain to tear through the softer material around the bone, namely, this fibrous aponeurosis of the quadriceps. So that usually in fracture by indirect violence there is a tear right across the fibrous tissue around the joint. Usually it does not give way along the actual line of fracture, and this has a rather important influence on the subsequent behaviour of the fracture. It is generally torn through at some little distance below the line where the bone gives way. But the chief thing to remember is, that in a fracture by indirect violence the injury is not confined to the bone, but is experienced also by the fibrous tissue which lies in front of the patella and on either side of it. And that is the reason why in these cases you get much greater separation of the two fragments and the failure of bony union.

Now we come to the symptoms which a patient shows when he has got a fracture of his patella. At the time of the injury he feels a sharp pain from the blow or the sudden giving way, and very often he actually hears the bone snap, or feels that it has snapped. There is also a good deal of loss of power in the knee. In most cases the patient is not only unable to extend the knee, but he cannot stand or walk. But you must be prepared to find that some patients after this injury are able to get about to some extent. Last year I had a case of a woman who broke one knee-cap through slipping downstairs. She made shift to walk about, and next day she managed to break the other knee-cap, and then she came in under my care with both knee-caps broken.

Then there is usually a good deal of swelling. That which follows immediately after the accident is due to effusion of blood. Later on, a day or two afterwards, the synovial fluid pours out, and so the swelling is partially produced by that as well as the blood. Sometimes the swelling is so great that you cannot feel the broken bone, and the skin may also be discoloured with ecchymosis.

If you ask what is the most frequent sign of fracture of the patella, you are often told that you can feel a transverse groove between the two fragments. But I want to warn you that sometimes you may be deceived by that. A patient falls upon the knee, and has a good deal of pain afterwards, and he comes to you with a swollen knee. You put your finger upon it and feel a depression running across the patella, and you think this is certainly a case of fracture of the patella. Well, it is not always so. Sometimes you get effusion of inflammatory lymph, and sometimes of blood-clot following an injury in the bursa over the patella, and that effusion is apt to arrange itself in masses, separated by a transverse groove, and the feeling presented to the fingers is very like that presented by a transverse fracture of the bone. I once was going round Cornelius ward, and I found two patients in adjacent beds, and both were said to have a fracture of the patella. I found that neither of them had a fracture of the bone, but simply an effusion in the bursa over the bone. I remember also another case, when I was assistant surgeon, of a patient in Cornelius ward, whose leg had been put up in a splint for what I was told was certainly a fracture of the patella. I examined him and found it was this other condition of things, so I had the splint taken off and told the patient to walk up and down the ward, and he did so quite comfortably, bending his knee and straightening it. The case was therefore discharged, and I am afraid I deprived the dresser of the credit he would have obtained for getting good bony union after a transverse fracture. Well, then, you must therefore not decide a case by the presence of the transverse groove alone, but always take hold of the two fragments of bone and feel if they move one upon the other.

Crepitus is often mentioned as a symptom, but as a rule you do not get crepitus. There are various reasons for this. In a short time the blood coagulates on the broken surfaces of the patella and so it is not so very easy to bring the surfaces of the patella into contact. There is another reason—because the tear of the fibrous expansion of the quadriceps is not quite at the same point as the fracture of the bone. So there is generally a sort of incurving of the fibrous aponeurosis, and a fringe of tissue rests between the two fragments of bone, and separates them from one another.

If it is a longitudinal fracture you do not generally get much of a groove, but you can find out the nature of the fracture by pressing with your thumb on the bone, and then you can feel half of the bone give way while the other half remains still; and you can make out whether there is a multiple fracture as well in the same way, by pressing the pieces of bone, and ascertaining whether they move independently.

Well, so much for the diagnosis of these cases. There is usually inability to extend the joint, there is the swelling and there is the groove between the fragments. But chiefly I would ask you to bear in mind that the fragments are movable one upon the other. It is of very great importance in these cases to try and make out whether the fracture is by direct violence or not. Of course, if the fracture is longitudinal or starred, it is pretty easy to make sure that it is due to direct violence. But most fractures that we have to treat are not of this nature, and some are of such a doubtful character that you cannot quite put them down in that particular category, and say they are fractures by direct violence. For instance, a woman came under my care this year with a fracture in which the lower part of the patella was broken into two pieces, separated from the rest of the bone by a somewhat oblique line of fracture. She was pretty sure that she had not struck her knee in coming downstairs, but that it had given way under her. As,

however, we heard that she was quite drunk at the time, we did not place much reliance upon what she said, and seeing little separation and that there was comminution, we concluded that it was a case of direct violence, and that there was no need for an operation. The knee was put up in a plaster splint, and within three weeks we could not make out the fracture at all.

The difficulty comes in in cases of transverse fracture. In reading some text-books you might easily come to the conclusion that cases of transverse fracture are always fractures by indirect violence. I do not think that is the case at all. *A priori*, you would expect that if the patella was broken on the sharp edge of a step, or any similar projection, the fracture would be transverse; and I am quite sure, from the careful cross-examination of many patients who have come under me with transverse fracture, that the injury has been caused by direct violence. There are many difficulties in making a sure diagnosis of direct violence in cases where the fracture is transverse. But it is very important for this reason: if it is a transverse fracture by direct violence, there is no need whatever for you to perform an operation upon the case; if it is a transverse fracture by direct violence, it will nearly always unite firmly by bone, and pretty rapidly, as this case did. This boy came in on March 21st, and went out on April 10th with good apposition, and the bone so united at the end of four or five months that I cannot make out where the fracture was. You must, therefore, cross-examine the patient and find out, when you have ascertained that he has got a transverse fracture, whether it is one by direct violence or not. Some help will be given you by the amount of separation. If, when you examine a patient's knee, you do not find much separation, and if he has some power of extending the knee—all that is in favour of its being a fracture by direct violence. Sometimes your patient will be able to give you such a history as will make you quite sure on the point. For instance, one man told me that he broke his knee by the edge of a bucket coming against it. That was almost certain to be a case of fracture by direct violence. At any rate, I should advise you, when examining a case of this kind, to try hard to make yourself certain whether it is a case by direct or indirect violence, because the prognosis is so much better, and the treatment is so much more simple if it is a fracture by direct violence. That is the reason, in those two cases of the man and woman who have been under my care this year, why I did not recommend an operation, and the results quite justified my having decided not to operate, for in both cases I got strong bony union, and they were able to go out within three or four weeks.

Then about the progress of these cases of fracture of the patella. If the fracture is by direct violence it will heal rapidly, and you will get very good union, but if it is by indirect violence there are two results that you are apt to get; one is that the patient will get a weak knee, and the other is that the patient will get a stiff knee. I have several reports of old fractures of the patella which have come under me this year. One I had to operate upon. A man of forty-eight, in August of last year, fell down and broke his patella. He was treated at some cottage hospital, and he came to me in January of this year because his knee was quite stiff and he could not walk at all; and it was very weak. In that case I, with some misgivings, operated upon him, and I found that the fragments were separated nearly half an inch, and that the upper fragment of the bone was united by fibrous tissue firmly to the femur. Although we divided the adhesions they formed again. When he went out his leg was much stronger, but the knee was still stiff.

The other bad result is that you get a very weak knee, a knee which the patient can only extend with a very feeble force. That is because you get union only by fibrous tissue, and the fibrous tissue, as soon as it is exposed to any strain stretches, until the patient gets a long fibrous band between the two fragments.

There are various reasons why you do not get good union in these cases. One is that the fragments are far apart. I do not think that is very important because, as a rule, as soon as the effusion has gone down the fragments come into pretty fair apposition. Another reason is that apposition is prevented by the turning in of the aponeurosis between the fragments. That, I think, is a very important reason. Another reason is something in the nature of bone. There are certain bones which do not throw out much callus, and which do not unite very readily. You have a good example of that in the skull bones; they throw out very little callus. It is much the same with the patella. Some people think that the soft callus thrown out is partly dissolved by the synovial fluid. Moreover, on one side of the patella there is cartilage, and on the other side there is strong fibrous tissue. Bones in the body covered by loose connective tissue throw out much more callus than bones covered by dense fibrous tissue or cartilage. But, whatever the reason,

there would seem to be something in the nature of the patella which renders it incapable of throwing out much callus.

Here is an illustration of this fact. The very first case I operated upon by Lister's method was in 1883. The case was that of a man aged twenty-four. I exposed the surface of the patella and brought the fragments together with a strong piece of wire in the usual way. That case did perfectly well. He was a strong muscular man, and seven years afterwards, the last time I saw him, the joint was quite strong, and there was no separation between the fragments. And yet I could move those fragments one upon the other from side to side; they had not united by bone. Something in the bone itself seemed to have prevented absolute bony union taking place.

In a number of cases, then, of fracture of the patella by indirect violence, where you do not get absolute apposition, the bones unite by fibrous tissue, and this fibrous tissue is apt to be very weak, and when a strain is put upon it by the action of the quadriceps muscle, it stretches until you may get two or three inches of separation between the fragments, and when that is the case the patient has to wear a kind of apparatus to keep his knee straight, and he may lose all power of extending his knee-joint. If he gets more than, say, one inch of separation between the fragments of his patella, he is apt to have a very weak knee. I lay some stress upon this point—this ankylosis of the knee-cap, or this very weak knee with stretched ligamentous union—because these are the results which justify us, when we have to treat fracture by indirect violence in people who live an active life, in running some risk by operating upon their knee-caps and employing the method of wiring the bones together: we wish to save them a long convalescence and these evil results, a weak or a stiff knee.

Now as to the treatment of these cases. If it is a case of fracture by direct violence, whether it be a case of longitudinal, or starred, or transverse fracture, the treatment is usually very simple. You must keep the knee extended so as to relax the quadriceps. Not only must you do so, but in order to relax the quadriceps completely you have to think of the attachment of the rectus muscle. Therefore, it is not only necessary to straighten the knee, but you must flex the hip through thirty or forty degrees so as to relax the rectus muscle which is a part of the quadriceps.

Then as to the swelling, some people employ an aspirator in order to remove the fluid. I have only aspirated twice in the large number of cases that have come under my care. In these two cases the knee-joint was so much distended by blood that the patients were suffering very great pain.

The best way to treat those cases in which you have decided not to operate is by applying a plaster of Paris splint, which keeps a uniform pressure upon the swollen limb, and, I think, induces the absorption of the fluid in the knee-joint as rapidly as possible. Cut open the splint next day, and as the effusion diminishes pare the edges of the splint and fasten it together with a bandage. In a short time you will find that the knee-joint recovers its ordinary shape and size, and the fragments come together. It is not necessary to do anything special under these circumstances to draw the fragments together. I shall speak of that later on. Usually when you apply a plaster of Paris in that kind of way, and take care that it remains tight and firm, you may allow the patient to walk about with the plaster of Paris three or four weeks after the accident, and in six or eight weeks, in cases of fracture by direct violence, you generally find that the fragments are firmly united, and that the patient can bend and use his knee.

Certain cases of fracture by indirect violence you will have to treat in a similar way. Either you will recommend an operation and the patient will refuse it, or you may consider the patient too old to be operated upon. I would be rather loth now, I think, to recommend an operation, except under special circumstances, in the case of a man who was over sixty. The best plan is to apply a plaster of Paris splint from the tuber ischii right down, enclosing the foot as well, and take care that it is kept very firm and tight.

Are you to do anything to draw the fragments together in these cases? That is a moot point. My impression is that it is best not to do anything, that your efforts ought to be directed towards getting all the fluid to disappear in the joint. You will do that best by pressure, and as soon as the fluid has disappeared you will find the fragments come naturally together. Many students are very anxious to do what they can in order to draw the fragments together, and there are various ways of doing it. I will show you one method that can be adopted. Supposing this is the knee (represented), there is the thigh. You must put on a back splint and foot piece. Always when putting on a back splint take care that it comes as far back as the tuber ischii. Supposing that (represented) is the back splint

going as far as the tuber ischii. The thigh (there) is simply a mass of muscles, so that you may look upon the bone as being surrounded by soft material which allows free movement unless you take care to carry you splint as far up the back of the thigh as possible. Here (represented) is the broken patella. The plan usually adopted is something of this kind. You put a piece of felt plaster above the upper fragment, and by means of strapping you draw this piece of felt downwards and backwards towards pegs or screws attached to the side of the back splint half way between the knee and the foot. That is the usual plan adopted. You will find a special splint in some of your books called the "Manning" splint. The principle is the same; you must apply some pressure above the upper fragment backwards and at the same time downwards so as to draw the fragments into apposition.

Now, that would appear at first sight to be a good mode of treatment, but it not quite so good in actual practice. There are several objections to it. In the first place, the pad acts upon the skin and soft parts more than upon the bone, so you are apt to draw the soft parts, the skin and superficial fascia downwards, while the bone remains behind. Another objection is that you are apt to tilt the upper fragment so that its broken surface looks forward. Another evil result is this: you interfere with the circulation above the patella, and the skin below is apt to become œdematous, and in some cases which I have had under my care I have found that the swollen skin actually may fold in between the fragments. In most cases I think you will find it best to trust simply to a well-fitting plaster of Paris splint, and so soon as the swelling goes down you will generally find the fragments get into good apposition.

You will have to keep your patient lying up much longer than in cases of direct violence. Usually you will have to keep them in bed three or four weeks. After that time you will generally allow them to go about on a wheel-chair. The limb must be raised by the patient's or the nurse's hands. The patient must not use his quadriceps, or else he will pull up the upper fragment and separate one portion of the bone from the other. Then in about five or six weeks, still keeping his plaster of Paris splint on, he can get about on crutches, and in about seven or eight weeks you will allow him to put his foot to the ground, stumping along with the plaster of Paris splint, but not bending his knee at all. Then about three months after the injury you must get him some sort of apparatus which he will have to keep on for a whole year. The convalescence in these cases is very slow indeed. You must not allow him to bend the knee; if you allow him to move it he will stretch the fibrous union and get a weak knee. I use something of this sort. Here is the patient's knee (represented), here is his broken patella, and the fibrous union there. What you will have to get for him will be this: a laced leather collar going round the lower part of the thigh, and another round the upper part of the leg. Then you will have to have side pieces of steel uniting the two collars, and furnished with a peculiar joint, allowing about thirty degrees of movement. Usually it is completed by a piece of elastic webbing in front, which helps to extend the knee-joint, and forms a sort of protection to the patient's knee. The patient should walk about with this apparatus until about a year has elapsed. As he gets stronger on his leg you can file a little bit of this metal in the hinge and allow him to bend his knee forty or fifty degrees, so as to give him rather freer movement than at first. By this means you allow the patient to move his knee-joint, and yet prevent him from putting such a strain upon the fibrous tissue as to allow it to stretch much. You will generally find—if, say, six weeks after the fracture you have got the fragments within one-eighth or one-quarter of an inch of one another—that in a year's time they are separated three-quarters of an inch, or an inch. But that is not a very serious matter. A patient who has got, say, fibrous union of about three-quarters of an inch, or an inch long, though he is not the man to select for a football team or to run hurdle races, will still be able to get about, to walk, or even run. But if the union get longer than that, then the patient will have a weak knee, and be permanently disabled.

I cannot to-day describe the operation treatment of these cases, as my time is up. The two methods of operation are Barker's and Lister's. We generally adopt Lister's operation. This is the operation which I performed in the case of three patients this year, and they all got sound union, and were able to walk about within three weeks of the time of injury. But you must remember that it is a very serious operation, and you must be careful to select your cases and to adopt every possible care, both in the operating and the subsequent treatment, to prevent the admission of septic material.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Taylor.

Mary	38.	Enterica.
	40.	Exophthalmic goître.
	41.	Acute nephritis.
	42.	Chronic nephritis.
	43.	Pneumonia following measles.
	44.	Gastritis.
	45.	Chorea.
	46.	Enterica.
	47.	Chronic peritonitis.
	48.	Gastric ulcer.
	49.	Broncho-pneumonia.
	50.	Proliferating papillomatous cyst of ovary.
Cot	57.	Malnutrition.
	58.	Pyrexia. ? Tubercular meningitis.
Philip	22.	Melanotic sarcoma removed from axilla. ? Recurrence in abdomen.
	23.	Emphysema. Bronchitis.
	27.	Enterica.
	28.	Enlarged liver. ? Adherent pericardium.
	30.	Intestinal growth.
	31.	Carcinoma of liver.
	32.	Locomotor ataxy.
	33.	Renal tumour in left loin.
	34.	Neuritis of left leg.
	35.	Chronic nephritis.
	36.	Abdominal hernia.
	37.	Chronic interstitial nephritis.
	39.	Enterica with relapses.
	40.	Double pleurisy with effusion.

Cases under Dr. Hale White.

Mary	14.	Aortic stenosis and regurgitation. Mitral regurgitation.
	16.	Pericarditis. Granular kidney. Albuminuric retinitis.
	17.	Phthisis. Chronic pleurisy.
	18.	Acute rheumatism.
	19.	Adiposis dolorosa.
	21.	Enteric.
	22.	Chronic tubal nephritis.
	23.	Movable kidney. Operation.
	24.	Gastric ulcer.
Philip	1.	Chronic nephritis.
	2.	Acute rheumatism. Mitral stenosis and regurgitation.
	3.	Psoriasis.
	4.	? Carcinoma of stomach.
	6.	Hæmoptysis. Mitral stenosis. Phthisis.
Philip	7.	Diabetes.
	8.	Enterica.
	9.	Diabetes. Ascites.
	10.	Jacksonian epilepsy.
	11.	Mitral stenosis and regurgitation.
	12.	Pleuritic effusion.
	14.	Focal myelitis.
	17.	Phthisis. Right apex. Tubercular laryngitis.
	18.	Retracted lung, left.
	19.	Appendicitis.
	20.	Obstruction to superior vena cava.

Cases under Dr. Bryant.

Stephen	21.	Empyema (left side).
	23.	Pleurisy with effusion.
	24.	Diabetes mellitus.
	25.	Enterica.
	26.	Mitral regurgitation.
	27.	Mitral stenosis and regurgitation. Tricuspid regurgitation.
	29.	Pericarditis with effusion. Mitral regurgitation.
	30.	Chronic tubal nephritis.
	31.	Appendicitis.
	33.	Appendicitis.
	34.	Mitral regurgitation.
	35.	Acute rheumatism. Aortic and mitral stenosis and regurgitation.
	38.	Post hemiplegic chorea. Phthisis.
	39.	Aortic stenosis and regurgitation. Dilation of the heart. Mitral regurgitation.
	40.	Sciatica.
	Cot.	Enteric fever.
Mary	26.	Enteric fever.
	27.	Infective endocarditis. Mitral regurgitation. Embolism of spleen and kidney.
	29.	Enteric fever.
	30.	Cirrhosis. Ascites.
	31.	Enteric fever.
	32.	Bronchitis. Hæmaturia. Acute nephritis.
	33.	Bowel obstruction due to growth in sigmoid (operation).
	36.	Chronic tubal nephritis.
	37.	Phthisis.

Cases under Dr. Perry.

Mary	1.	Cirrhosis of liver. Alcoholic neuritis.
	6.	Ulcer of rectum.
	7.	Chorea; 4th attack. Mitral regurgitation.
	9.	Enterica. Relapse.
	12.	Bright's disease.
Cot	51.	Left empyema.
	52.	Diphtheria. Tracheotomy. ? Laryngeal stenosis.

Stephen	1.	Eczema.
	2.	Acute rheumatism. Mitral regurgitation.
	3.	Right empyema. Ruptured into lung.
	4.	Osteo-arthritis.
	5.	Acute rheumatism.
	7.	Left hemiplegia. Cerebral hæmorrhage.
	8.	Aortic stenosis and regurgitation. ? Mitral regurgitation and stenosis.
	10.	Typhoid fever.
	11.	Empyema; right. Resection of rib.
	12.	Acute nephritis.
	13.	Empyema; left.
	13.	Left sided pleural effusion.
	14.	Acute Bright.
	16.	Mitral stenosis. Regurgitation.
	18.	? Pernicious anæmia.

"Clinical."

John	4.	Gall stones. Operation.
	5.	Typhoid. Convalescent.
	6.	Pericarditis.
	7.	Pyrexia.
	8.	Pain in left hypochondrium. ? Renal.
	11.	Pleuritic effusion.
	12.	Old appendicular abscess. Operation.
	13.	Typhoid.
	15.	Bright.
Miriam	18.	Mitral stenosis and regurgitation.
	20.	Typhoid. Convalescent.
	22.	Rheumatism. Convalescent.
	23.	Pelvic tumour.
	25.	Subdural abscess.
	26.	? Typhoid.
	27.	Mitral regurgitation and stenosis. Tricuspid regurgitation.
	28.	Hemiplegia. Aphasia.
	29.	Appendicitis.
	30.	Gastric ulcer.
	31.	Mitral regurgitation and stenosis. Aortic stenosis.
	32.	? Tubercular kidney.
	34.	Pneumonia.
	35.	Marasmus.

In the Surgical Wards.

Cases under Mr. Howse.

Naaman	4.	Old separated tibial epiphysis.
	7.	Osteoma of skull.
	8.	Carcinoma recti. Colotomy.
	10.	Spinal caries. Psoas abscess.
	11.	Varicose veins and varicocele.
	16.	Condylomata. Excision.
	17.	Vesical calculus. Litholapaxy.
	18.	Talipes equino-varus.
Dorcas	3.	Varicose veins.
	4.	Lupus of face.
	7.	Burns.
	9.	Concussion.
	14.	Recurrent carcinoma mammæ.
	18.	Tubercular sinus in Furneaux-Jordan stump.
	Cot B.	Tubercular hip.
Astley Cooper	3.	Fractured humerus and ruptured urethra.

Cases under Mr. Davies-Colley.

Job	3.	Cleft palate.
	5.	Epithelioma linguæ. Excision.
	6.	Tertiary ulceration of nose. Rhinoplasty.
	7.	Chronic vaginal hydrocele.
	10.	Stricture of urethra. Dilatation.
	20.	Tubercular testis. Varicocele.
	21.	Tubercular abscess over sacrum.
	22.	Mastoid disease. Antrectomy.
	23.	Epithelioma of helix. Excision.
	24.	Inguinal hernia.
Lydia	2.	Inguinal hernia. Radical cure.
	3.	Ventral hernia.
	8.	Thyroid enlargement.
	10.	Acute osteo-arthritis.
	14.	Tumour of mandible.
	17.	Fractured tibia and fibula.
	18.	Branchial cyst.
	20.	Adeno-cystoma of thyroid.
	22.	Fibroma of sheath of rectus.
	Cot C.	Suppurating hæmatoma.
Cornelius	1.	Bullet in leg.
	6.	Fractured ribs. Emphysema.
	7.	Fractured patella.
	8.	Fractured fibula.
	10.	Compound fracture of tibia and fibula.
	12.	Crushed hand.
	16.	Hæmarthritis. Knee.

Cases under Mr. Lucas.

Lazarus	1.	Talipes equino-varus.
	2.	Necrosis of femur. Sequestrotomy.
	3.	Tubercular testis. Excision.
	4.	Tubercular knee.
	5.	Varicose veins.
	6.	Epithelioma of lip.
	8.	Traumatic stricture of urethra.
	9.	Hæmorrhoids.
	15.	Retained testis.
	17.	Sarcoma of inguinal glands.
	19.	Syphilitic arthritis.
	22.	Spinal caries.
Martha	4.	Cleft palate.
	6.	Tubercular glands. Chlorosis.
	7.	? Renal calculus.
	13.	Fistula in ano.
	14.	Rachitic tibiæ. Osteotomy.

15. Compound fracture of tibia and fibula. Screwed.
17. Double inguinal hernia.
18. Femoral hernia. Kelotomy.

Cot D. Tubercular knee.

Astley Cooper 7. Compound comminuted fracture of leg. Amputation through thigh.
9. Fractured sternum and ribs.
10. Fractured tibia.
17. Double inguinal hernia.
25. Extra-capsular fracture of femur.

Cases under Mr. Golding-Bird.

Luke 6. Malunited tibia. Osteotomy.
7. Double inguinal hernia. Radical cure.
8. Multiple gummata and syphilitic arthritis of knee.
9. Epithelioma of bladder.
13. Stricture of urethra.
14. Ununited tibia. Wired.
16. Epithelioma of hand. Old burn. Cicatrix.
17. Vesical calculus. Suprapubic lithotomy.
18. Extra-dural abscess. Old mastoiditis.
19. Chylocele. Radical cure.
20. Strangulated inguinal hernia. Kelotomy.

Charity 1. Tubercular glands in neck.
3. Old appendical sinus.
6. Pes cavus. Transplantation of tendons.
11. Fractured patella.
12. Tubercular knee. Excision.
13. ? Tubercular hip.
17. Tubercular knee. Aspiration.
18. Talipes equino-varus.

Cot A. Spinal caries.

Cot B. Suppurating meningitis. Cerebral abscess.

Astley Cooper 14. Fractured tibia and fibula.
15. Fractured tibia.
19. Bruised kidney. Peritonism.
21. Lacerated wound of hand.
28. Compound fracture of metatarsus.
29. Extra-capsular fracture of femur.

Cases under Mr. Jacobson.

Naaman 19. Epithelioma of floor of mouth.
21. Recurrent inguinal hernia.
22. Inguinal hernia and retained testis.

Dorcas 19. Multiple compound ganglion.
20. Cystic disease of breasts.
21. Enlarged semimembranosus bursa.

Samaritan 8. Septic ulcer of foot. Syme's amputation.

Cases under Mr. Symonds.

Job 13. Double inguinal hernia.
15. Gall-stones. Cholecystotomy.
17. Enlarged tonsils. Adenoids.
18. Suppuration of frontal sinus.

Patience 1. Cellulitis of arm.

Samaritan 7. Psoas abscess.
11. Cellulitis of arm.

Cases under Mr. Lane.

Lazarus 11. Talipes equino-varus.
12. Appendicitis.
14. Varicocele. Excision.

Martha 10. Torticollis. Division of spinal accessory nerve.
11. Moveable kidney. Nephrorraphy.
12. Congenital absence of fibula.
13. Mastoid disease.

Patience 3. Erysipelas of face.

Samaritan 12. Dry gangrene. Amputation of toes.

Cases under Mr. Dunn.

Luke 1. Tubercular glands in neck.
2. Varicose veins. Excised.
3. Malunited metacarpal bone.

Charity 20. Carcinoma recti. Colotomy.
22. Inguino-labial hernia. Radical cure.
23. Tumour in abdomen.

Patience 14. Erysipelas of face.

Samaritan 9. Abscess in neck.

Notes from Corea.

It is some time since I wrote a short article for the Gazette under the above heading, and since that time many things have happened here. To me personally the most important event was an attack of typhus fever through which I passed last March. It is unnecessary to go into details here; I need only state that I could not have had better treatment and care at home. The fourth day of my illness I was taken in an easy chair up to our hospital in the capital, "Seoul," and immediately had the kind attention of Dr. Baldock and our two nurses there. The day after my arrival in Seoul I became unconscious, and remained so for a week or so. Perhaps an interesting medical or psychological fact worth mentioning is that during my period of unconsciousness I underwent a mental sensation almost exactly similar to that of a case mentioned in Fagge's "System of Medicine"—namely, the feeling as if the bed I was lying on was on fire, and I seemed to actually hear the crackling of burning wood, and then water being brought in and thrown over me to put the fire out. In the case mentioned by Fagge the water seemed to be brought from a pond, but in my case they seemed to be bringing it from the next room.

This was not the only mental sensation I went through during my unconscious state, but my memory can now only retain unconnected fragments of them, of great interest to myself, but of no practical value to anyone else, I think.

Soon after my return to Chemulpo I became installed in the new hospital, which is being pushed forward to

completion as rapidly as possible. At present I cannot use the ward, but am using the operating room as a temporary ward, and can take in six patients, but as this is not the time of year for getting many patients, it has not been necessary to use all the beds.

I have had one cataract operation to perform, but do not think it will be successful, owing, I think, to shreds of the capsule starting secondary opacities. I scarcely expected it to be successful, as it was the first I have undertaken.

Another operation was for tuberculous testicle in a boy eight years old. After extraction of the diseased testicle the boy has greatly improved. At the time of doing the operation I found the testicle almost completely surrounded by dense fibrous tissue, which had to be cut through before it could be reached.

The first case of inguinal hernia that I have seen here appeared the other day, and will probably require the radical cure. Hernia is not common here.

When the hospital is quite finished we shall have room in the ward for about twenty patients, besides a second ward especially for foreigners, and also accommodation for two nurses. I wish I could say that the hospital was well supplied with drugs, instruments, &c., but as at present only £15 per annum is allowed me for drugs, and no allowance for new instruments, one has to exercise a very rigid economy.

When one reads of the lavish expenditure on hospitals at home, one begins to feel a little jealous, and wish that a small portion were sent out to us; on the other hand, it makes us feel the value of what we have got.

There is little more of medical interest worth mentioning, except that we have received news of there having been a few cases of plague at Newchang, in North China, and in consequence the Customs service are taking precautions lest it should be brought here and as Custom's medical officer I am to go aboard a steamer coming in from Newchang, and make enquiries, &c., and should there happen to be any cases on board they will be put into quarantine on an island close by.

I have nothing more of interest to add, but if anyone reading this is moved to have pity on our poverty and wish to help us, a box of instruments or drugs, or even a good operating table, would be, like the Owl, the Waverley and Pickwick pen, a boon and a blessing to men.

St. Luke's Mission Hospital, Chemulpo. W. A. C.

Pass List.

Royal College of Surgeons of Edinburgh.

Examination for the Fellowship, October, 1899.

C. W. Booker. R. B. Stamford.

Nursing Notes.

"Season's Greetings" cards in summer are helpful in reminding us that Christmas will arrive some six months later; they are a landmark of the seasons, but if you want a real reminder, get an out-patients' collecting card, and you will find Christmas bearing down upon you at an alarming rate, quite out of proportion to the money that should roll in, or the blanks to be filled up. There is absolutely no difficulty in obtaining them, as every other nurse has one she would willingly dispose of. If you are ambitious you can have a collecting book; it needs courage to undertake to fill one, also a fair amount of cheek.

Subscriptions remind us that though all the nurses have expressed great willingness to join the library, neither books or subscriptions are rolling in as quickly as they should; as yet not more than fifty have been taken to the office.

The quarterly fire drill took place this week. As an exercise it is exhilarating, but it would be more popular amongst the nurses if it were less public. Why not have a permanent chute fixed on to the New Nurses' Home in a secluded corner where the nurses could practice on wet days?

From another hospital than Guy's.—Female ward: ? Typhoid. H.P. to new pro, "Nurse, show me the patient's abdomen;" and nurse, not learned in anatomy, wanders all over the ward to find it.

The entertainments this winter are beginning with an entirely ecclesiastical flavour. If we are not born in the purple, we shall be able to bask in its shadow, ('bask' doesn't seem to be quite the right word, but we can't find another) owing to the kind invitation of the church committee.

On the preceding day the Bishop will also open the Babies' Home at Forest Hill (the Matron's particular enterprise). "The Haven" seems to be a very suitable name. Many other suggestions have been made, but none better it.

"L'INCONNUE."

Passim.

The war in the Transvaal has been the occasion of the dispatch of a large number of the Royal Army Medical Corps to the front. Among men who have recently left Guy's, the following have been appointed to their respective stations: Lieutenant H. B. Onraët goes out with the 2nd Battalion Scots Fusiliers, Lieutenant H. D. Packer is appointed to No. 10 Field Hospital, and Lieutenants L. Humphry and V. J. Crawford will go out to No. 16 Field Hospital. Meanwhile Mr. F. E. Fremantle, late editor of the Gazette, who has been mobilizing for the past fortnight, left for South Africa yesterday as a civil medical officer attached to the Army Medical Corps. Mr. Fremantle is also the accredited war correspondent of the Gazette during the forthcoming campaign.

The Obstetric Examiners at the Examination Hall seem to have a peculiar predilection for ploughing Obstetric Residents at Guy's. No sooner does a man get his standing orders from the House Committee here than the experts on the Embankment playfully present him with a pink paper. If we remember aright, Mr. W. T. Milton, after getting a First Class Honours at the London M.B. in Obstetric Medicine, received his congé from the examiners at this time last year. Mr. H. Leader, also a London M.B., has spent a pleasant year paying quarterly visits to these same jesters with ultimate success this week. Mr. H. W. Bruce, one of the soundest men we possess at Guy's at the present time, was incontinently ploughed on Tuesday evening last amid the good-humoured incredulity of all who knew him.

The strange thing about this business is that only in this particular subject and in the College Examinations do these glaring mistakes occur. One never knows of such a thing happening at the London University Examinations or in the Medicine or Surgery Examinations at the College. It really seems as if the Obstetric gentlemen on the Embankment were, in vulgar language, getting at each other. On any other grounds the whole affair is incomprehensible.

The Gazette to-day is full of appeals. In another column the secretary eloquently pleads the cause of the Debating Society, and would whip up all loiterers for this evening's debate. For the benefit of those who cannot read what is set before them, we would announce again that the subject for debate is: "That the time has come for the abolition of the South African Republic." The difficulty will arise in finding an opposition. Judging from Parliamentary parallels, Mr. Lindsay is the only gentlemen who will be able to take the Irish view of the question, and harass the Government by expressing sympathy with the Boers.

We also publish a much-needed letter from the President of the Residents. The habit of smoking in the surgery at all times of day, and especially smoking while actually attending to patients, cannot be too strongly condemned. It is forbidden by regulation, and gives a very poor idea of the education of the hospital men to the ignorant but critical outsiders. It is hoped that this reminder—the second within twelve months—will avert the necessity of more stringent means being taken to stop this growing evil.

It is a strange thing, but men never seem to realize how important it is to at any rate try and keep up appearances before the patients and the outside public. In the surgeries and in the wards it is often forgotten that everybody, from house-physician down to the humble ward clerk, represents in some degree the medical profession in general and the hospital Staff in particular, and that there is no keener critic than the average hospital patient. Those patients who know the hospital and its ways thoroughly appreciate its benefits and make allowances, but to the casual applicant a crowd of men smoking and talking with friends and nurses to the neglect of their duties makes a very poor impression.

On Monday, October 30th, the Bishop of Rochester will open "The Haven," 182, Devonshire Road, Honor Oak Park. "The Haven" is a home for children connected with the Guy's Laundry Hostel, and is the outcome of a long-considered scheme for some place where the children in question can be looked after in the fresh air. "The Haven" is situated quite close to the Nurses' new projected Athletic Club House, which is in process of active building.

On the following evening there will be a conversazione at which the Bishop of Rochester will be present, to be held in the Court Room, at the Hospital.

The Smoking Concert has been fixed for Saturday, November 18th, at 8.30 p.m. As a good smoking concert costs money, it has been decided to charge 2s. for admission. This will prevent overcrowding, and the moderate price will not prevent all those who wish for a good concert from coming. We would again call on all new men who could help to communicate in writing with the President of the Residents, Mr. E. W. S. Rowland, who will be most happy to meet them and see what they can do. The concert will be preceded by a house dinner, particulars of which will be announced later.

It has been decided during the present year to have six lectures on the various duties of a doctor. These addresses will be by well-known public men, and it has been proposed to hold them in the Chapel at 5 p.m. on Mondays once a month. As these lectures will be wholly unconnected with any society, all men will be welcome, and they should be well attended. Notices of dates and particulars will be posted later. Among the speakers will be G. W. E. Russell, Esq., Canon Newbolt, and Canon Gore.

Dr. Lockhart Stephens' address on the Sandow method of physical culture has borne speedy fruit. A class for this method under a regular instructor has been announced, and already a large number of men have signified their intention of joining. The fee for the course is quite moderate, £2 2s., and allows for twenty-six lessons, not necessarily taken consecutively, so this arrangement ought to suit even the busiest of men. The result on the physical standard here should be interesting.

Against Lennox last Saturday our opponents had the best of the game. Our forwards, due chiefly to the absence of two or three regular men, and the poor display of a few taking part, were beaten, they very seldom got the ball in the scrum; and when they did, invariably kicked it among our opponents or "heeled" it out at the side of the scrum. Mullins and Trail worked hard; Milsom followed up well.

At half Jackson got through a lot of work; his dribbling considerably helped his side on several occasions. Wyatt's tackling was good, but he has yet to learn to pass neatly and at the right moment. E. Morgan was the best of the three-quarters; he displayed an accurate knowledge of the game, and should prove a decided acquisition to our XV. The others played fairly well, and made the most of the few chances offered them. They should learn to tackle low. Our back tackled well on a few occasions; he must kick sooner. It is fatal for a back to have his kick charged down.

On Wednesday last we played Cambridge University. Our side was strengthened by the inclusion of Ayre-Smith, fresh from victories in Australia, among the forwards, and Alexander and Walker outside the "scrum." Pye-Smith played back, and kicked well. He must remember a back's duty is to tackle low; his tackling high let one man through. We expected more from our three-quarters. Alexander tackled well and was of great service to us. O'Brien did not seem to realize which three-quarters he was opposed to, and more than once our wing-man had to face three of the University third line. Morgan had few opportunities, and with one exception made the most of them. We have seen Sime play a better game. Our half-backs, Walker and Jackson, did a good deal of offensive work, and passed out fairly well. They might have prevented Hacking and Fasson getting away as often as they did.

The forwards proved quite equal to, if not better, than the formidable eight opposed to them. Our pack got the ball much oftener and "heeled out" well. The captain, Trail, and Ayre-Smith played well. Thomas was prominent on the line out. Milsom, as usual, followed up hard. Our eight seemed to have forgotten how to "wheel" the scrums, and should practice. Their strong point appears in combined forward rushes, which frequently gained them a deal of ground.

The season of the Association Football team has opened fairly well. Only one match has been played, that against the Old Harrovians, and the result was a draw, with a score of one goal each. The Guy's team played a very fair game considering the large number of new players, but the earliness of the season was evident in the marked diminution of pace shown in the later stages of the game. Several new men played, and all seem promising players. Wiltshire, the captain, as usual, played a very sound game. In Association as well as Rugby, as the secretaries are always pointing out, individual play is of no value without combination, and it is only by regular practice and practice together that the reputation of the

hospital can be worthily kept up. It is to be hoped that all men, new as well as old, will take this advice to heart.

On Saturday evening next, October 28th, Messrs. A. Kirkman and F. W. Shenton will give a demonstration of X-Ray apparatus and photographs. The demonstration will include the method of taking skiagraphs, screen views of medical as well as surgical subjects, and the method now adopted of localizing foreign bodies when found. We are requested to ask house-physicians and house-surgeons to send if possible to the meeting patients with phthisis and other tubercular lesions, and cases of interest for examination and demonstration on the fluorescent screen.

The new notice-board in the colonnade for clinical lectures is a great improvement, and has supplied a long-felt want. It will be quite useless, however, unless the subject of the lecture is advertised in advance. Most men know who is going to give the lecture; what they want to know is what the lecture is going to be about. As the member of the Staff must know what he is going to lecture on, it ought to be quite easy to announce the subject two or three days in advance, instead of leaving a blank space at the bottom of the board.

The Final Fellowship Classes are now in full swing, and should prove a most valuable addition to the classes for senior men up for the higher examinations. The names of those who are taking charge of them—Mr. Jacobson on Clinical Surgery, Mr. Dunn on Operative Surgery, Mr. Fripp on Surgical Pathology, and Mr. Steward on Anatomy—are sufficient testimony to their great value. The arrangement of these classes has satisfactorily filled a large failing in the syllabus of the Medical School, and there is now no reason why men should in future go elsewhere for preparation for the Final Fellowship.

In the *British Medical Journal* of last week there appeared a paragraph congratulating Dr. Dennis Embleton, of Claremont Place, Newcastle-on-Tyne (now retired), on his attaining the age of 90 years on October 1st., and trusting that, for some years to come, he might enjoy his well-earned repose from active practice. Dr. Dennis Embleton is an old Guy's man, took his M.D. Durham in 1853, the M.D. Pisa in 1836, and the F.R.C.P. London in 1859. Among the greatest of his virtues may be counted the fact that he is one of the original members of the Clubs' Union, and is a regular subscriber to the Gazette.

Notes of Introductory Lecture to Dental Students.

By Mr. W. A. Maggs.

According to my usual custom I shall first make some few remarks, chiefly for the encouragement and help of the new students.

When you read the dental prospectus, and the regulations of the Royal College of Surgeons, you will probably say to yourself that much is expected of you during the space of two years. That is undeniable, but what I want to emphasize is that the personal effort or will of each student has far more to do with success than any extraneous, or fortuitous circumstances.

Wendell Holmes says, "I have great confidence in young men who believe in themselves."

I should like each of you to possess some enthusiasm for your profession, and you may depend upon it energy, personal ambition, and industry, are of greater importance than high intellectual gifts. All probably desire a good professional status, but not all are willing to make the necessary sacrifice of time and steady work for its accomplishment.

The lectures at Guy's are specially arranged at early and late hours, so that as little interference as possible shall take place with your day's work in the conservation room. I would advise you to devote all available time to practical work, for it will tell in your favour in after-life. A minimum number of fillings, crowns, and dentures is required of you, but that done it in no way follows that you are competent men, much less brilliant operators. A much larger amount of practical work can be done during the two years, and by all means do it, as manual dexterity and self-confidence can only be acquired by experience.

It has been said, "For book-learning there is a substitute—practical work: for practical work there is no substitute." I should like it to be generally acknowledged in the profession that a Guy's man is synonymous with a good practical dentist.

In addition to operative work lectures and reading are necessary, so that our treatment as far as possible shall be founded upon sound surgical principles, and not empiricism. It should be a pleasure after your day's work at this hospital to study the subjects of the curriculum.

As specialists, too, you must possess a general acquaintance with odontology, and a study of comparative dental anatomy broadens one's views of the relationship of the animal kingdom to man.

For some years I was a member of the committee of the Benevolent Fund of the British Dental Association. This charitable fund is intended to help, as far as its limited means permit, those members of our profession, who have from some unfortunate or unforeseen circumstances been compelled to seek for assistance. Not infrequently a dentist applying for help attributed his difficulties to the fact that he had not kept himself abreast with the times, the consequence being that he was obliged to move from the more fashionable part of a town, or locality, to a poorer district, and so on from bad to worse.

Now this was an object-lesson and a sad one, and it taught me the necessity of always striving to keep in touch with recent literature, and new methods of practice and treatment.

We all know how greatly our mechanical work has improved, and time been saved, by the use of swagers, duplicating materials, contour palates, and polishing plates. Let us live up to our advantages and learn if formagen will supersede arsenious acid in the treatment of exposed and septic pulps, or solila take the place of gold foil for fillings, or possibly porcelain or glass inlays supplant solila.

Is eucaine better than ethyl-chloride or cocaine as a local anæsthetic? Is nitrous oxide gas with oxygen preferable to pure nitrous oxide?

The man who keeps an unprejudiced and open mind —not a simple matter, as the tendency is to work in a groove, being easier—and who is always anxious to do his utmost for his patient's benefit by saving him pain and time, will ultimately prove the most successful.

At the present day surgical operations are conducted with true aseptic precautions, and such Listerian treatment is equally necessary in dental practice. Some time ago a senior member of the staff of the Dental Hospital of London spent a morning here, and upon leaving he said, "Surgical cleanliness is well taught in Guy's dental department." This commendation was gratifying to hear, and let us take care that we continue to practise strict cleanliness.

I should like to draw the attention of students registered on and after January 1st, 1897, to the regulation of the College of Surgeons requiring a certificate of three years' dental mechanics before being eligible for the first professional examination. Therefore students who now join this hospital having only done two years' mechanics cannot present themselves for this examination until November, 1900.

Of course it need not prevent them from attending lectures on mechanics and metallurgy during the winter session, and the two years' hospital course need not be prolonged on this account, as the second examination can be taken six months after the first.

My only object in referring to the regulation is to prevent men from being disappointed at a later period, say in May next, when some of them may fondly have hoped to present themselves for examination.

I also wish you to know of a regulation of the General Medical Council, which will come into force on January 1st, 1900. It is that a dental or medical student, before registration, will be required to present a certificate of having passed the 1st class College of Preceptors' examination (or its equivalent), whereas until the date mentioned a 2nd class certificate will suffice.

It is probable that many dental men registered with the lesser certificate may at some future time desire to take medical qualifications, and the question is, Will the registered dental student be exempted from a higher preliminary examination, or will the latter be enforced?

I hope the General Medical Council will exempt registered dental students from the higher examination, but in order to prevent any difficulty arising, I would suggest that you advise your dental friends to take out a course of chemistry at one of the recognised schools, and forthwith to become registered as medical students. It is hardly necessary to say that this advice in no way applies to any of you, for as soon as you enter Guy's you are registered as medical students.

The hospital library contains all the standard dental works and current literature. Suggestions by students for additions can be made at any time, and the committee is always anxious to add to its store of text-books.

The Comparative Anatomy Museum of the hospital is invaluable for teaching purposes. It contains most of the typical dentitions of vertebrate animals.

The museum of the Royal College of Surgeons is open to students on the first four days of the week.

The museum of the Odontological Society can be visited by students on Monday, Wednesday and Friday evenings upon presentation of a member's card.

The Natural History Museum is open throughout the year, and it probably contains the best series of specimens of the dentitions of vertebrates in the Kingdom.

I trust you will become familiar with the contents of these museums, and I can assure you that Dental Anatomy can be best learnt in this practical manner.

Gentlemen, be ambitious, and always keep before you a higher goal—the Conjoint Diplomas and the Fellowship of the Royal College of Surgeons—and so add your share to the lustre of this school and the dental profession.

Notice.

THE BEANEY SCHOLARSHIP: GUY'S HOSPITAL.

The Beaney Scholarship in Materia Medica will shortly become vacant. The Scholarship, open to candidates who have received part at least of their medical education at Guy's Hospital, is of the annual value of £30 and is tenable for three years. Further particulars may be obtained from the Dean, to whom applications must be addressed, at the Medical School Office, Guy's Hospital, London Bridge, S.E., not later than November 13th, 1899.

Guy's Hospital, October 19th, 1899.

In Lighter Vein.

Mr. Fremantle has left for the Transvaal. Residents in the College may now look for their letters in the Lodge window.

I notice that Sir Redvers Buller is taking out a horse named Biffin. I trust that Biffin will survive the first encounter.

There has been another fearful disaster in the College Midwifery examination. Evidently Charity seeketh not her own.

The Church Committee purpose giving a musical "sworry" on November 1st. Among the other attractions will be a real live Bishop. The exhibit is guaranteed genuine and is exclusively engaged for one night only. Visitors are requested not to touch.

On October 30th "The Haven" will be opened. Information is rather scarce, but it is understood that "The Haven" is a quiet home in the country provided by the Nurses' Club as a Saturday-to-Monday resting place for its members.

"I don't want to boast," said the H.-S. one night at the Residents' table, "but I have just done my eighty-fourth op. during my H.-S.-ship." "And I," said an H.-P. impressively, "have just heard my thousand and thirteenth râle. Nelly, kindly go round and ask the gentlemen what they will take to drink!"

The present Residents are determined to wipe out the sins of their predecessors, and are arranging a first-class "Smoker" for November 18th. It has been decided, very wisely as I think, to make a small charge for tickets; thus the somewhat heavy expenses can be met, and if anything is over the funds of one or other of the Christmas charities will be benefited.

Several old favourites will appear, and some excellent outside talent will be imported. But this is not enough. It is imperative for the complete success of the entertainment that new men of "ours" should be heard. There must be many such, and it is their duty to reveal themselves. Let me whisper a word in the ears of the possessors of hidden talents. To sing at "Smokers" is an excellent way of becoming acquainted with the best people; and really the best people are quite worth knowing.

The dramatised version of Mr. Hall Caine's "Christian" has been produced in London with but small success. The "realistic" hospital scenes of the book find no place in the play. As improvements appear to be needed they might be introduced. They would make excellent "comic relief."

From *Treatment* I cut the following:—"The importance in cases of perforating gastric ulcer of early recognition and operation is clearly emphasized in an instructive and interesting clinical lecture by Dr. Bernard Shaw (Guy's Hospital Gazette, July 15th).

Now, we do not object to *Treatment* getting copy from this paper, in fact, we feel rather flattered by it; but it is well to point out that G. B. S. does not contribute to the Gazette. Possibly when we get rich we shall arrange for a series of "Lectures Pleasant and Unpleasant," but the time is not yet.

The following conversation was overheard the other day by a correspondent. Unfortunately our informant mentions no names. "Are you better?" "Yes, thank you; I'm much better. I've been riding. I think it's such good exercise. I think it's like swimming, don't you?"

Learn now the woes of Mrs. Flack. She writes as follows to her medical attendant:—

Sir—Mrs. Flack cannot get on at all the pain in the back and chest are even worse than they were a week ago after eating I have such a weight on my chest that the food all comes back again if it does not go through soon after I have had it my bowels are very irregular from Friday until Monday I had nothing through me and since then it has been all the other way and I have the reaching from the wind rupture very bad and my feet and legs are so very cold at night only hot when I have a can of hot water to them I have raised a deal of glutt and a lot passed through me I think it is a bad indigestion it makes my heart very bad as well has my chest and cold settled inside would you please to send me a bottle of medicine for it the baby's face is about the same she has a very good appetite now she passed a large worm on Monday from Mrs. FLACK.

Papers by Guy's Men.

A Case of Ovariotomy. By Ernest H. Tipper, M.R.C.S., L.R.C.P. Lond., L.S.A., and Arthur E. Philipps, M.R.C.S., L.R.C.P. Lond., L.S.A.—*Lancet*, 7th October.

Mr. W. C. C. Pakes.

He is called by his friends "Paki" and is an eminent bacteriologist. For the initiated no further account of him is necessary—for the rest (an insignificant minority) we continue as follows:—

He entered the hospital as a First Year's Student, and remained so for some twelve months. Before he had completed his appointments his name became associated with that of the Bacillus of Rauschbrandt. He subsequently found it necessary to retire to the Continent for a season, until the affair had quieted down, and his luxuriant locks had had time to grow. He left this country a student—he returned to it a scientist.

He was largely instrumental in founding the Guy's Hospital Debating Society, and at one time used frequently to orate there. He has since been elected Vice-President, and as such is debarred from taking part in the debates. We believe he was elected unanimously. He is a real live professor, rolls cigarettes with cheerful alacrity, and is withal an excellent good fellow. He is an adept at the ready answer which turneth away wit, and lives in a glass house at which few have ever been observed to cast a stone.

Correspondence.

To the Editor of Guy's Hospital Gazette.

The Debating Society.

Dear Sir,—May I call the attention of your readers to the opening meeting of the Debating Society to-night. It is impossible to over-estimate the importance of acquiring while still a student the faculty of expressing ideas in intelligible and fluent English—a fact to which pulpits and lecture-rooms bear melancholy witness.

But apart from the personal gain, it is the duty of Guy's men to do their best to maintain their societies in a position worthy of our traditions.

May I also plead for a little more practical interest on the part of the audience. "Applause is," according to Mr. Gladstone (no mean authority), "the breath of an orator's nostrils." Interruptions, questions and explanations are essential to brilliant counter-thrusts. Points of order should not be neglected. The stranger and maiden speaker, of course, receives a cordial and unharassed welcome, but the older man should be discriminated against. Prosiness, dulness (the unpardonable crime) must be determinedly resisted and not tamely born, if a debate is not to become an infliction. Opposition is good for individuals as for Corporations.—Yours sincerely,

THE HON. SECRETARY.

Smoking in the Surgery.

Dear Sir,—I wish through the Gazette to call the attention of the men working in the Front Surgery to the rule which exists against smoking there. During the last few months the habit has become more and more frequent, and as a rule, the younger the ward clerk the more smoke does he bestow on the scalp-wound under his care. It is possibly detrimental to the scalp-wound from an aseptic point of view, but it is certainly so to the reputation and to the best interests of the hospital.

I feel sure that this subject has only to be mentioned, and that the dressers will help the residents to maintain the observance of this very necessary regulation.—I am, yours, &c.,

THE PRESIDENT OF THE RESIDENTS.

Guy's Hospital Students' Glee Club.

A general meeting was held on Tuesday, October 17th. In the unavoidable absence of Dr. Lauriston Shaw, Dr. Spriggs took the chair. The following were elected as officers for the ensuing year:—President, Dr. Lauriston Shaw; secretary, Mr. H. McD. Parrott; treasurer, Mr. Greenfield; librarian, Mr. C. A. D. Bryan; and as extra members on the committee, Messrs. A. E. H. Pakes and Claxton.

The secretary desires to call the attention of men interested in part-singing to this society. It is now in a very flourishing state, both financially and otherwise; it has a most efficient and able conductor; and the excellence of its work is shown by the success of the two concerts held last season. Men who are able to read music are especially welcome, and even more so are men with tenor voices, for of the latter quality of voice the society is much in need. Unless a notice is issued to the contrary, the first practice will be held in the Court Room on Friday next, October 27th, at 4 p.m., and on every succeeding Friday. It is hoped that every member will do his best to attend these practices regularly and punctually.

From the Gazette's Special Pathologist.

O. J. C., Maritzburg.—This growth from the tongue has the structure of a papilloma, with much thickening of the epidermis. There is no evidence of its being malignant from the microscopical examination.

R. P. L., Clifton.—This growth is a melanotic carcinoma, such as would originate in a pigmented mole of the skin.

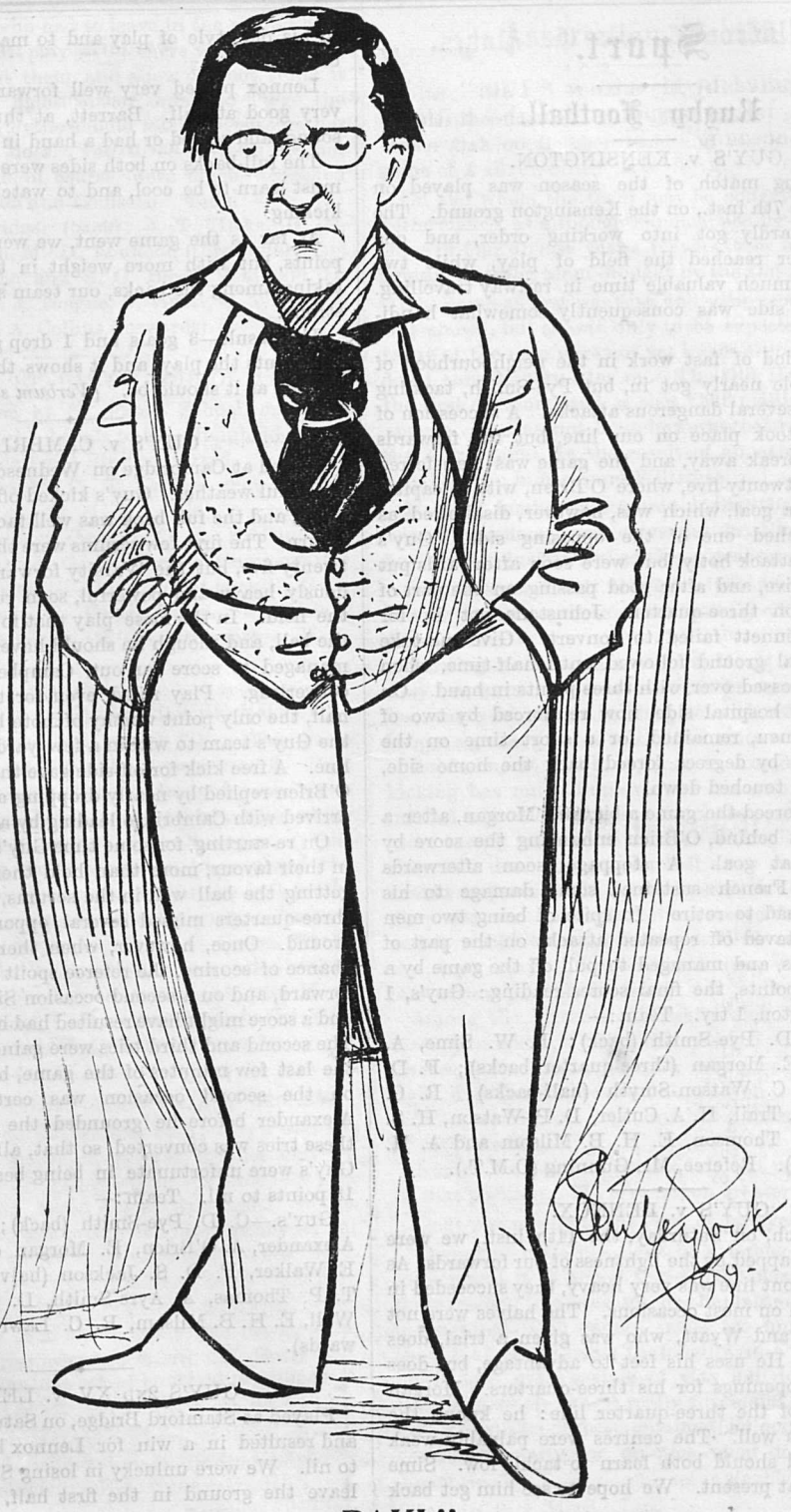
H. H. W., St. John's College Park.—No tubercle bacilli can be found in the sputum.

H. G. A., Nottingham.—No tubercle bacilli can be found in the sputum.

H. B. P., Barking.—No tubercle bacilli can be found in the sputum.

R. H., Ramsgate.—No tubercle bacilli can be found in the sputum.

PATHOLOGIST.



"PAKI."

Sport.

Rugby Football.

GUY'S v. KENSINGTON.

The opening match of the season was played on Saturday, the 7th inst., on the Kensington ground. The team had hardly got into working order, and one member never reached the field of play, while two others spent much valuable time in railway travelling. The hospital side was consequently somewhat handicapped.

After a period of fast work in the neighbourhood of our goal, Goole nearly got in, but Pye-Smith, tackling well, stopped several dangerous attacks. A succession of scrummages took place on our line, but the forwards managed to break away, and the game was transferred to the home twenty-five, where O'Brien, with a capital drop, landed a goal, which was, however, disallowed, as the ball touched one of the opposing side. Guy's continued to attack hotly, but were soon afterwards put on the defensive, and after good passing on the part of the Kensington three-quarters, Johnstone got in for them, but Bennett failed to convert. Give-and-take play in neutral ground followed until half-time, when Kensington crossed over with three points in hand. On resuming, the hospital side, now reinforced by two of the missing men, remained for a short time on the defensive, but by degrees forced back the home side, and Nicholson touched down.

Guy's now forced the game a bit, and Morgan, after a tricky run, got behind, O'Brien enhancing the score by kicking a neat goal. A stoppage soon afterwards occurred, as French sustained some damage to his clavicle, and had to retire. In spite of being two men short, Guy's staved off repeated attacks on the part of their opponents, and managed to pull off the game by a margin of 2 points, the final scores reading: Guy's, 1 goal; Kensington, 1 try. Team:—

Guy's.—C. D. Pye-Smith (back); F. W. Sime, A. O'Brien and E. Morgan (three-quarter backs); F. D. Jackson and C. Watson-Smyth (half-backs); R. C. Mullins, D. H. Trail, H. A. Cutler, D. P. Watson, H. S. French, A. R. Thomson, E. H. B. Milsom and A. H. Wall (forwards). Referee, Mr. Gunning (O.M.T.).

GUY'S v. LENNOX.

In this match, on Saturday, the 14th inst., we were severely handicapped by the lightness of our forwards. As the opposing front line was very heavy, they succeeded in getting the ball on most occasions. The halves were not quick enough, and Wyatt, who was given a trial, does not save well. He uses his feet to advantage, but does not make any openings for his three-quarters. Morgan was the best of the three-quarter line: he knows the game and runs well. The centres were palpably weak in defence, and should both learn to tackle low. Sime is not in form at present. We hope to see him get back to his old style of play and to mark his opponent more closely.

Lennox played very well forward, and Cookson was very good at half. Barrett, at three-quarter, was very sound, and scored or had a hand in all the tries.

The full-backs on both sides were very weak. Harrison must learn to be cool, and to watch his opportunity for kicking.

As far as the game went, we were fairly beaten at all points, but with more weight in the scrum and better taking among the backs, our team should turn out fairly strong.

The result—3 goals and 1 drop goal to 3 tries—about represents the play, and it shows that our kicking is not as good as it should be. *(Verbum sap).*

GUY'S v. CAMBRIDGE.

Played at Cambridge on Wednesday, October 18th, in beautiful weather. Guy's kicked off against the sun and slope, and the full back was well tackled before he could return. The first few scrums were thus in the Cambridge twenty-five, but the 'Varsity forwards, who are tremendously heavy and powerful, soon rushed the ball down the field. In the loose play that followed, Sisterton got the ball, and though he should have been easily tackled, managed to score far out, Campbell with a fine kick converting. Play ruled even for the rest of the first half, the only point worthy of note being a loose rush by the Guy's team to within a few yards of the Cambridge line. A free kick for off-side gave the 'Varsity relief, but O'Brien replied by nearly dropping a goal, and half-time arrived with Cambridge leading by a goal to nil.

On re-starting, for some time Guy's, with slope and sun in their favour, more than held their own, the forwards getting the ball well in the scrums, but the halves and three-quarters missed several opportunities of gaining ground. Once, however, when there was an excellent chance of scoring, the referee spoilt it by ruling a pass forward, and on a second occasion Sime got clean away, and a score might have resulted had he passed accurately. The second and third tries were gained by the 'Varsity in the last few minutes of the game, both by Collett, who on the second occasion was certainly held up by Alexander before he grounded the ball. Only one of these tries was converted, so that, all things considered, Guy's were unfortunate in being beaten by as much as 13 points to nil. Team:—

Guy's.—C. D. Pye-Smith (back); F. W. Sime, K. B. Alexander, A. O'Brien, E. Morgan (three-quarters); F. E. Walker, F. D. S. Jackson (halves); R. C. Mullins, T. P. Thomas, A. Ayre-Smith, D. H. Trail, A. H. E. Wall, E. H. B. Milsom, R. C. Lawry, G. Shorland (forwards).

GUY'S 2nd XV. v. LENNOX.

Played at Stamford Bridge, on Saturday, October 14th, and resulted in a win for Lennox by 1 goal and 2 tries to nil. We were unlucky in losing Shannon, who had to leave the ground in the first half, and could not come

back, and Louisson, who had to leave in the second half. The forwards did not play well; there was not enough keenness or go about them, and a few did not think it necessary to shove. It is rather unfair to judge the halves, but Watson-Smythe should learn to pass rather more often than he does. The three-quarters did not get any chances, and, of course, were much weakened by the loss of Shannon and Louisson. Team:—

Guy's.—R. D. Bridger (back); J. T. Hicks, H. N. Grose, S. H. Shannon, M. D. Louisson (three-quarters); C. F. Watson-Smythe and S. C. Brown (halves); H. Parrott, G. Mum, E. J. Tongue, F. Watts, G. T. Collins, F. A. Beattie and M. A. Collins (forwards).

GUY'S 3rd XV. v. ST. PAUL'S SCHOOL 2nd XV.

This match, played at St. Paul's School, ended in favour of the hospital by 2 goals to nil. Reinhold scored both times, and Rendall and Ring converted.

Amongst the forwards, G. T. Collins showed good form. Team:—

Guy's.—R. D. Bridger (back); C. A. E. Ring, G. Willan, C. H. Reinhold, G. H. Sherris (three-quarter backs); A. E. Kynaston, —. Harvey (half-backs); G. T. Collins, J. Malim, J. W. Featherstone, R. Rendall, G. H. Leall, L. Doudney, G. F. Humphreys, N. I. Spriggs (forwards).

GUY'S 4th XV. v. PARK HOUSE "C."

Played at Kidbrooke on October 7th. This game ended in the defeat of Guy's by 7 points to 3. Park House opened the score with a fine dropped goal. Soon after Guy's were awarded a penalty kick, with which Gardiner was successful from a difficult angle. In the second half our opponents scored an unconverted try. The forwards did not attempt to obtain the ball in the scrums, and did not use their feet sufficiently. Team:—

Guy's.—J. J. Gardiner (back); A. C. Green, H. H. Carter, C. Denyer, J. W. Gromitt (three-quarter-backs); P. F. Minett, H. Wallace (half-backs); Osburne, H. C. Winckworth, R. Felton, E. H. Adams, Costobadie, Maybury, G. C. F. Robinson, H. D. Smart (forwards).

GUY'S 4th XV. v. OLD ALLEYNIANS 3rd XV.

Played at Norwood on October 14th; Guy's won the toss, and, although two short, pressed for the first ten minutes, but our better trained opponents forced the pace and crossed the line twice before half-time. In the second half the game was more even; our opponents got over twice, both tries being converted, while J. J. Gardiner got in for Guy's but was called back. The final score was, Old Alleynians, 16 points, Guy's nil. The whole team suffered from bad training, and the forwards must learn to pack better and to follow up. Team:—

Guy's.—J. N. Gardiner (back); H. T. Palmer, G. Russel, J. J. Gardiner, R. O. Williams (three-quarter-backs); P. F. Minett, Harvey (half-backs); H. C. Winckworth, A. C. Dickson, R. Felton, E. H. Adams, Costobadie, H. D. Smart (forwards).

Association Football.

GUY'S v. OLD HARROVIANS.

This, the first match of the season, was played at Honor Oak on October 14th, and resulted in a drawn game of 1 all.

On the whole the team may be congratulated on the performance, as although handicapped by the absence of three or four of last year's players, they held their own against a strong team brought by the Old Boys.

The game at first was fast, and some good combination was shown, but as was only to be expected, seeing that many of the men were not yet in condition, it slackened down considerably later on. The Old Harrovians were the first to score with a shot that really gave Heap no chance. It was not long, however, before Barber made the score equal, as the result of an excellent piece of play between himself and Wiltshire.

Nothing further was scored during the game, though several excellent shots were put in, Norton especially having hard luck in not getting a goal on one occasion.

In the second half the game became much slower, though at times there were some good rushes by the forwards.

Turning to individual players, Heap, in goal, showed very fine form. On one occasion he came out too soon, but there is no doubt that he understands the goal-keeper's game.

Robinson, at full-back, was in excellent form; his kicking has much improved, as has also his pace. He infused a good deal of dash into his play, which proved most useful. Corfe was tried at left-back. He is rather slow, and does not get the ball away soon enough, but should improve with more experience. Of the halves, Shepherd was obviously not recovered from his illness, and it would be quite unfair to draw conclusions from the day's play. The half-back line was perhaps the least strong part of the team.

Among the forwards, Wiltshire and Barber were the most prominent. Wiltshire worked hard and well. Barber, a freshman, played a very good game at inside right, and should prove an acquisition to the team. He dribbles and shoots well, and has a thorough knowledge of combination.

Norton was tried at outside left, but was really wasted in that position. He is of much greater value at inside.

Dent was not up to his form of last year.

There are certainly signs of a strong eleven for this season, and it is hoped that all the members will follow the excellent example set by the captain and secretary in training. One cannot insist too much on the fact that it is only by being thoroughly fit, and by getting to know each other's style of play individually, that the team as a whole can be really successful, and this fitness and knowledge is best obtained by going down to the ground regularly for practice once or twice a week. Team;—

Guy's.—Heap (goal); Robson and Corfe (backs); Greenfield, Shepherd and Smith (halves); Dent, Barker, Wiltshire, Manser and Norton (forwards).

GUY'S v. CHRIST COLLEGE, FINCHLEY.

The opening match of the season for the 2nd XI. was played at Finchley, on Saturday, October 14th, and resulted in an easy win for the hospital by 5 goals to 0. We were not strongly represented, as the captain and four of last year's team were away. The men were not by any means fit, and throughout the game were slow in getting on to the ball. At times the combination between the forwards was good, and they would often have been seen to greater advantage had the halves followed them up the field better. All the forwards scored except Lacey. The shooting was fair, but we let several good opportunities slip. As a side we were considerably faster than our opponents. Of the new men Watney played a much steadier game than Bartlett at back. Edie was useful on the extreme right but held the ball too long, and did not make the most of his opportunities in front of goal. Chignell is also a fast and useful man, but must keep his own place on the field and not send the ball out on to the wing when close in front of goal. Team:—

Guy's.—H. H. Carter (goal); H. A. Watney, G. N. Bartlett (backs); A. Leeming, J. Braithwaite, J. W. Gromitt (half-backs); T. H. Edie, L. A. Chignell, H. K. Lacey, B. Rust, P. A. Peall (forwards).

Appointments.

MEDICAL SCHOOL APPOINTMENTS, NOV., 1899.

The following appointments have been made by the Medical Council and approved by the House Committee:—

Clinical Assistants in the Medical Wards.—Messrs. W. H. Brailey (Dr. Taylor); T. J. Wright (Dr. Hale White); H. N. Clarke (Dr. Pitt); C. B. Thomson (Dr. Perry).

Clinical Assistant in the Surgical Ward.—Mr. P. W. L. Camps (Mr. Davies-Colley).

Dresser in the Eye Wards.—Mr. P. H. Ward (Nov. 1st).

Obstetric Dressers.—Messrs. W. Murray, L. Pern (Nov. 16th).

Surgeons' Dressers.—Messrs. H. G. Rashleigh, T. A. Matthews, D. L. Morgan, F. E. Welchman, G. Clarke, T. H. B. Dobson (Mr. Howse); R. S. Roper, J. D. Bridger, E. Shelton-Jones, H. Wacher, E. C. Bevers, E. G. Wales (Mr. Davies-Colley); F. G. Gibson, J. A. B. Hammond, S. Hodgson, S. J. Ormond, K. V. Trubshaw, N. F. Ticehurst (Mr. Lucas); D. Forsyth, P. T. Manson, F. W. Smith, H. Bentley, H. Davies-Colley, G. S. Graham-Smith (Mr. Golding Bird).

Guy's Hospital.

October 30th, 1899.

CIVIL.

Harding, C. Headley, L.R.C.P. Lond., M.R.C.S., has been re-appointed Medical Officer of Health by the Whittlesea Urban District Council of Health.

Hodson, F., M.R.C.S., has been re-appointed Medical Officer by the Hornsea Urban District Council.

Parkinson, C. H. Watts, M.R.C.S., D.P.H. Edin., has been re-appointed Medical Officer of Health by the Wimborne Rural District Council.

Ward, J. A., L.R.C.P. Lond., M.R.C.S., has been appointed Medical Officer by the Urban District Council, Grays.

MILITARY.

Colonel W. E. Saunders, C. B., R.A.M.C., is transferred from Bombay to York, and Lieutenant H. Simson, R.A.M.C., from Netley to Devonport.

Captain E. M. Pilcher, Lieutenants H. D. Packer, L. Humphry, V. J. Crawford, and H. B. Onraet, R.A.M.C., have been detailed for duty with the Army Corps, proceeding to South Africa on active service.

Reviews.

Materia Medica, Pharmacy, Pharmacology and Therapeutics. By W. Hale White, M.D., F.R.C.P. (J. & A. Churchill, pp. 637. Fourth edition).

We only have to chronicle the fourth edition of this pre-eminent work—the second within twelve months. Even in so short a period it has been thoroughly revised, several parts have been re-written, and eighteen pages of new matter have been inserted. The body of the book remains what it was before, the most complete and most useful handbook on Materia Medica yet published.

Birth.

WALLIS.—On September 29th, at Roman Road, Old Ford, E., the wife of Sidney Seymour Wallace, M.R.C.S., L.R.C.P., of a son.

Marriages.

BASCOMBE—GURNEY.—On October 11th, at the Parish Church, Milton, Hants, by the Rev. J. G. Kelsal, M.A., Rector, Ernest Dare Bascombe, of Bournemouth, to Annie Ada Gurney (*née* Harfield), of Hengistbury, Bournemouth.

SWAIN—HARRISON.—On October 3rd, at St. Paul's Church, Clifton, by the Rev. Canon Bindley (cousin of the bride), Principal of Codrington College, Barbadoes, and assisted by the Vicar, the Rev. W. E. Haigh, James Swain, M.D., M.S., F.R.C.S., of 4, Victoria Square, to Hilda May, daughter of A. J. Harrison, M.B., J.P., Failand Lodge, all of Clifton.

Ed.—H. L. E.

Contents.

	PAGE
With Mr. Howse in the Wards of Guy's Hospital	453–459
Hospital News	459–460
Report of the Council of the Hostel Children's Home, "The Haven"	460–462
Pupils' Physical Society	462–464
Passim	465–466
Correspondence: Guy's Hospital Chess Club	467
Nursing News	467
Metropolitan Asylums Board	467
Chapel News	467
Nursing Notes	468
The Bishop of Rochester at Guy's	468–469
Pass List	469
Contemporaries Club	469
Guy's Hospital Debating Society	470
The Opening of "The Haven": By One who was There	470–471
Reviews	471–473
In Lighter Vein	473–474
Sport: Rugby Football—Cardiff v. United Hospitals; Guy's 2nd v. L.C.C.; Guy's 2nd v. R.M.A. 2nd. United Hospitals' Hare and Hounds	474–476
Appointments	476

Calendar of Coming Events.

November, 1899.

Sat. 4.—Messrs. Lucas and Lane's take-in; Drs., F. G. Gibson and K. V. Trubshaw; Cl., J. F. Northcott.
1 p.m., Clinical lecture by Dr. Pitt.
G.H.R.F.C., I.—Rosslyn Park, away.
II.—Rosslyn Park, home.
III.—Tonbridge Sch. 2nd, away.
IV.—Lewisham "A," away.
G.H.A.F.C., I.—Reigate Priory, away.
II.—Furzedown Park, home.

Wed. 8.—1.15 p.m., Clinical lecture by Mr. Davies-Colley.
G.H.A.F.C., I.—St. Leonards, away.

Thur. 9.—Messrs. Golding-Bird and Dunn's take-in; Drs., D. Forsyth and H. Bentley; Cl., H. A. Gaitskell.
Probable date of Primary Fellowship Exam.
G.H.C.U.—Address by R v. A. E. Barnes-Lawrence.

Fri. 10.—Exam. for L.D.S., Eng.

Sat. 11.—1 p.m., Clinical lecture by Dr. Pitt.
G.H.P.P.S.—Pathological Meeting.
G.H.R.F.C., I.—Catford Bridge, home.
II.—London Irish, away.
III.—Blackheath Prp. Sch., away.
G.H.A.F.C., I.—Old Cranleighans, home.
II.—Old Cranleighans "A," away.
Last day for applying to Registrar for Form of Entry for B.S. Lond.

Tues. 14.—Meeting of the Dental Society at 4.30 p.m.

Wed. 15.—1 p.m., Clinical lecture by Mr. Howse.
G.H.R.F.C., I.—Royal Engineers, away.
II.—Westminster Hospital, home.

Thur. 16.—Messrs. Howse and Jacobson's take-in; Drs., S. Clarke and T. H. B. Dobson; Cl., W. B. Secretan.

Sat. 18.—1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I.—Bedford, away.
II.—Beckenham, away.
III.—Hammersmith "A," home.
IV.—S. Paul's Sch. III, away.
G.H.A.F.C., I.—Ewell, away.
II.—Ewell II, home.

Guy's Hospital Gazette,

NOVEMBER 4, 1899.

With Mr. Howse in the Wards of Guy's Hospital.

Reprinted from the *Clinical Journal*, Sept. 27th, 1899.

GENTLEMEN,—This boy has very extensive lupus of the foot, more especially affecting the sole. It is not very common to find the foot so extensively affected. The condition has recurred a great many times, notwithstanding that it has been scraped thoroughly and nitric acid applied. On this recurrence I proposed amputation, but the parents thought they would like to have another attempt made at saving the foot, and so it has been scraped again, and nitric acid has been reapplied. You will see that the disease is very extensive, and I am afraid the ulceration has gone very deeply. It is an ordinary case of lupus vulgaris—not one of the more peculiar forms. In the belief that iodoform is pernicious to the tubercle bacillus you will see that it has been used here plentifully. It is said that there is now less discharge. The boy says he has had it treated four times in this hospital before, and once at home.

You will notice that on his legs there are curious pigmented, reticulated marks, symmetrical on both legs. It is met with a good deal in persons who sit before the fire, and is called "ephelis ab igne," which is really a misnomer or contradiction in terms, meaning, as it does, "sunburn from the fire." The pigment is probably derived from the broken-down colouring matter of the blood, and is lodged in the cutis. In the black man the pigment is in the conical cells of the rete Malpighii. We know that this coloration is due to pigmentation, and not to mere congestion of the blood-vessels, because it does not disappear on pressure. If it were a mark due merely to over-fulness of the vessels, pressure

from the finger would empty them, and the dark colouration would vanish. But you see it remains permanent. The reticulated pattern of the marking is probably due to the pigment being deposited along the course of a network of venous channels in the cutis.

This next patient is a man aged fifty-two, who had a small strangulated femoral hernia. We found at the operation a very thickened sac, indicating that the hernia had been down a long time. At the bottom of the sac was a very small knuckle of intestine, so that it is probably a "Richter's hernia," in which form only a small portion of the calibre of the intestine is in the strangulated hernial sac. Thus the lumen of the bowel remains partially patent, and therefore there is no absolute obstruction. The material most commonly passed is fluid and flatus. Only flatus was passed here. If one had the choice, I think one would rather have a hernia of the whole calibre of the intestine than a Richter, because while fluids and flatus pass, obstruction is not complete, the symptoms of strangulation are not marked, and therefore it is only late in the disease, when gangrenous ulceration of the bowel and general peritonitis have set in, that the patient seeks advice. The probability of a fatal result is therefore much greater. Here we have fortunately operated early. There is reason to believe that in this case the obstruction was complete as far as fluids were concerned, because he had not passed anything for two days except flatus; and at the operation, within a few minutes of the release of the strangulation, the patient passed a most abundant evacuation of fluid fæces (about half a gallon); and within the first hour after the operation three other evacuations of the same character, but less abundant, took place. This could only have occurred through the release of the strangulation, and therefore through the bowel being made patent by the operation.

In these cases of femoral hernia we now always attempt radical cure of the hernia after the reduction of the intestine. This is done by separating the sac all the way round from the surrounding tissues, applying a ligature to its neck, then cutting off the sac just below the ligature. The stump is then pushed into the crural canal as far as possible, and the skin wound closed with salmon-gut sutures.

The next patient is a man aged fifty-nine. He had a large melanotic sarcoma in the groin, which started from a small tumour in the skin on the inner side of the groin. This had involved the superficial inguinal glands and also one of the glands lying deep in the pelvis between the peritoneum and the pelvic fascia. The dissection of this gland was very difficult, and I had finally to put a ligature round its deep vascular connections and cut it off, dropping the ligature into the wound. I then closed the superficial wound without leaving any drain in it. This I afterwards regretted; it was trusting too much to primary union in a patient so feeble as this one was. Union at first took place, and as there was no rise in temperature we thought things were going well. But some hæmorrhage subsequently took place into the deep part of the wound, and the skin incision separated. A good deal of broken-down blood and pus came away, and we had to wash the wound out. It then slowly granulated up from the bottom, and ultimately did well. I am inclined to think it would have been better policy to have packed the wound from the first until all tendency to hæmorrhage had ceased, and healthy granulations had appeared. In all these soft sarcoma cases there is a great tendency to hæmorrhages. This militates against primary union, and generally requires the use of a drain.

The next case is that of a boy aged eight, who has a tumour on the right side of the abdomen, some distance above Poupart's ligament. It is much larger when he is walking about, but some of it can be reduced with a slight gurgle, so that part of it is undoubtedly hernia of intestine. A considerable mass remains irreducible, however, and the nature of this mass is the question for diagnosis. There is no testicle in the scrotum on the right side, but there is on the left, so the swelling may have something to do with an undescended testis; if so it is very much larger, harder, and higher up in the abdominal wall than usual. It is elastic and uniform in its contour, and too deeply placed in the abdominal wall to examine for translucency. We shall discover what it is when we explore, but I think it is probably misplaced testis enclosed in a tunica vaginalis containing fluid (hydrocele); or there may be a hernial sac containing omentum with the testis in some unascertainable relation to it. These misplaced testes generally have no capacity for producing spermatozoa, and should be removed as soon as they give rise to inconvenience, as they are rather frequent sources of trouble hereafter. In this case there is no question about the importance of operation, on account of the size of the tumour and the undoubted co-existence of a hernia with it. By the operation we shall effect a radical cure of the

hernia, and if the diagnosis is correct we shall take away the testes as well.

[*Note.*—At the operation the tumour was found to be misplaced testis enclosed in a tunica vaginalis containing a considerable amount of fluid. The aperture in the abdominal wall through which it had passed was at least two inches above the position of the internal abdominal ring. Associated with it was a hernial sac containing adherent omentum. The testis itself was a small deformed one with a very large unravelled epididymis, with cysts in the latter. It was removed, the omentum cut off and ligatured, and the aperture in the abdominal wall stitched up. The patient left the hospital well in about three weeks.]

This man, aged twenty-two, has had nephrotomy performed, or perhaps I should rather say an exploratory operation about the kidney. The patient was very tender in the region of the kidney, and had many of the signs of stone in that organ. We explored the kidney very thoroughly, but could not find any stone, though I passed a needle into its substance in several directions. We accordingly closed the wound up, and the result is that the pain about the region of the loin has vanished. All that remains now is an occasional smarting when he passes water, probably due to uric acid in the urine. The explanation of the relief given by operation in such a case as this is somewhat difficult to understand. Such cases, however, are not very uncommon, and many surgeons have had a similar experience. In two cases with which I am acquainted the relief appeared to be due to cicatricial tissue forming about the kidney after the operation, and thus fixing it more firmly in its position. Neither of these cases, however, were cases in which the diagnosis of floating kidney could be made before the operation.

This boy, aged fourteen, has had a Stokes-Gritti amputation performed. That is the form of amputation at the knee-joint which is mostly seen in Guy's. A long anterior skin flap reaching from above the condyles down to the tubercle of the tibia is first cut. In reflecting this flap the ligamentum patellæ is cut through and the knee-joint opened, the flap being thrown upwards with the patella in it. A section is then made through the patella from above downwards, removing the posterior or cartilage-covered surface of this bone. The posterior flap is then made, the skin incision being carried nearly as low as the anterior to allow for retraction. The muscles are cut through opposite the joint, and separated from the bone to just above the level of the condyles. The femur is sawn through in its broader part just above the condyles. The section of the patella is then turned up against that of the femur, and united with it by a suture or ivory peg. This produces an extremely good stump, which admits of weight being borne upon the end to a certain extent. The cicatrix becomes placed posteriorly from retraction of the muscles in the posterior flap. Thus the skin just over the lower part of the patella (the kneeling skin) corresponds with the end of the stump, and enables it to stand a certain amount of pressure. This case has healed up with great rapidity. The operation was performed a little over three weeks ago; he has been well for a week, and the patella has united with the femur. The stump which ensues is not at all clavate, as in most amputations at the knee-joint, and is therefore very advantageous for the instrument maker to fit an artificial limb on to. The weight of the body in such a case as this is distributed between the end and the sides of the stump, whereas in an ordinary case the sides have to bear the whole of the burden; this sometimes causes a good deal of inconvenience from dragging upon the cicatrix.

The next patient is a man aged forty-one, on whom Syme's external urethrotomy for stricture was performed yesterday. There was a good deal of tendency to hæmorrhage, as there usually is where, in addition to the stricture, the prostate is also at fault. In dressing him after the operation the catheter was by mistake not fastened in, and it came out this morning with a rush of urine and could not be got back again. The dresser and house-surgeon made some attempts to replace it, but naturally an incised urethra is somewhat tender, and they failed. This emphasises the importance of fastening the catheter in for the first few days in all the more complicated cases. As he is somewhat sore from the attempts, and as he will pass water quite well without an instrument for the next twenty-four hours, we will leave him at rest to-day and pass a catheter to-morrow.

This man, aged fifty-four, comes in with a large gelatinous sarcoma of the foot. He has been in before, when it principally affected the dorsum of the foot. We then attempted to excise it, but it extended between the metatarsal bones into the sole. It was impossible to excise this part cleanly, so we scraped it out with the sharp spoon, and then plugged the cavity to control the bleeding and to make it fill up with granulation tissue. This it did, but at that time we were uncertain of the nature of the

growth. It is now pronounced to be round-celled sarcoma, and there are undoubted signs of recurrence both on the dorsum and in the sole, especially on the former. We shall have to amputate, and the question is what amputation we ought to do. Under ordinary circumstances a Syme's amputation at the ankle would be the right one to choose, but it is out of the question here on account of the excessively bad tissue about the ankle-joint and leg from old varicose ulceration, from which this man has suffered. He will have to make up his mind to an amputation much higher up—above all this diseased tissue. Practically the question lies between an amputation at the "place of election," —where I think I might perhaps get just enough sound tissue,—and one of the knee-joint amputations. I believe I shall choose the latter as being safer in this case. You will notice that there are no signs of secondary disease.

The age of this man is sixty-nine, and he comes with a big ulcer round the leg just above the ankle. Diseases are generally classified according to their etiology, and in the case of ulcers there are syphilitic, varicose, cancerous ulcerations, and so on. There is another classification of ulcers, viz., according to their anatomical peculiarities; for example, there is the healing ulcer, the indolent ulcer, the weak ulcer, and the irritable ulcer, and many others. You all know the healing ulcer with its small, red, florid granulations, discharging laudable pus, its surface up to the level of the surrounding skin, and its advancing edge of bluish epithelium or epidermis. Then there is the weak ulcer, where there are large, pale, shiny granulations projecting beyond the level of the surrounding skin, often called "proud flesh." In the case now before us the surface of the ulcer is depressed below the level of the surrounding skin. The surface consists of greenish brown, sloughy material, with just an island or two of granulation tissue mixed with it. This material is really dead and degenerating granulation tissue and inflammatory lymph. The discharge from the ulcer is not purulent, but consists of yellowish serum. The character of the edge is well marked; it is hard, thickened, sharply defined, not painful, but with a callous margin; in fact, we have all the characters which go to make up an indolent ulcer. These ulcers may last for years. The patient has already had this for several years. He is not an in-patient, in fact he refuses to come in; but being a relation of one of our employés, he often comes to the hospital for advice. Like many other people, he likes to have his own way. He listens to what everybody says, and then goes home and does what he pleases. I told him to stay in bed, but he has only done so very partially. He is not now following any occupation. I now recommend warm boracic fomentation to be applied four or five times a day; this will keep it antiseptic, and promote the formation of healthy granulation, and then when the ulcer is in a more healthy condition, a skin-grafting may be done with advantage for him. If he were to rest it entirely it might be well in about two months. Of course there would be some tendency for it to break down again when walking about, but that risk may be minimised if he takes due care of himself. In view of the possibility of there being something specific about it, I gave him some biniodide of mercury at one time, and there would be no harm in giving him some again now, as it may help the absorption of the indurated edge and facilitate the healing.

In a case of exceedingly chronic ulceration like this, perhaps I ought to say something about the oxygen treatment of ulcers. I believe it is claimed by Dr. Stoker that the cicatrix left when the ulcer is treated by oxygen is more permanent than when treated by other methods, and if that is so it would be worth trying it. I have no personal experience if this be true or not, and I think it would be somewhat difficult to prove, because ulcer cicatrices break down from such very different causes, and at such different periods, even in the same patient. But my own impression of oxygen, locally applied, is that it is only a very useful form of antiseptic, and I believe equally good results are obtained by many other antiseptics, *plus* rest. It is most important to do everything we can to produce a good scar, especially for ulcers in the leg, where the new tissue is very liable to break down when the patient begins to walk about after a long period of lying down.

One cause of rapid breaking down after the ulcer has skinned over, is that often the new skin forms over very unhealthy granulation tissue; such new skin is nearly always very thin and weakly formed. It is often good policy, when commencing the treatment of a chronic ulcer, to destroy the whole surface with some escharotic, so as to compel the tissue below to throw out new and healthy granulation tissue as the eschar separates. The new skin will form much more rapidly and permanently over this new granulation than over the old ulcerated surface. Another cause of breaking down arises from impeded venous circulation above the cicatrix, as from varicose veins, or

from various constitutional troubles. The former (the varicose veins) may often be cured by operation, and this contributes greatly to the stability of the cicatrix. This venous impediment is the reason why elastic support, as from elastic stockings, Martin's elastic bandages, &c., is so often of use in preventing an ulcer breaking down after cicatrisation. However, if in most cases it could be definitely proved that the oxygen cicatrix was less likely to break down than others, I should not hesitate to employ it.

You will remember we saw this patient with melanotic sarcoma of the pelvis two or three days ago. Creolin has been used here for the dressings, and you will notice it has irritated the skin somewhat. I think boracic dressing is preferable; it is not such a strong antiseptic, but it does not irritate. In the operation we rather imprudently united Poupart's ligament with deep sutures to the muscle above it, and the skin incision with superficial sutures without using any drain; and as these melanotic sarcomata tend to bleed a good deal, I am afraid some hæmorrhage occurred in the pelvis underneath the deep suture. Anyhow the wound did not heal primarily, and must now fill up with granulation. The patient has no constitutional symptoms; his temperature varies but little, and has been for the most part 99°. He will now have boracic lotion fomentations, changed every four or five hours.

The next case is one of piles in a man aged forty-two, who is progressing very well. With regard to this patient, I should like you to observe that he has had a posterior proctotomy performed, in addition to the usual piles operation. The anus was very small and contracted, and I always make this addition to the operation in such cases, because it facilitates the early actions of the bowels, and causes them to be performed with comparatively little discomfort. It heals up very rapidly, and in no wise interferes subsequently with the action of the sphincter. The sphincter is not cut across in performing the operation; only the fibres springing from coccyx separated. These subsequently unite in the healing process, and the function of the sphincter becomes as good as it was previously.

This young man, aged twenty-one, is a very tubercular patient; the tubercle has especially affected the knee, which was so much disorganised that it was doubtful whether excision of the joint would be successful; but we tried it, and he has done exceedingly well, in fact it healed in about four or five weeks, and since that time he has had on a silicate splint. To-day, for the first time since the operation, he will try and get about with crutches, with the foot slung up at first. At so early a period after the operation as this, we cannot expect the union of the bones to be very strong, and it would be highly imprudent to allow him to attempt getting about without artificial support. I have known patients who have tried to get about even at the end of three months, without artificial support, who have developed a painful condition of the part which has thrown them back a good deal.

We have in the wards at present three patients suffering from stricture of the urethra. They all present rather different aspects of the complaint, and may be advantageously compared together. The first is a man aged forty-two, who has been treated by simple dilatation. We have dilated the stricture up to the size of a No. 10 English catheter, and there seems every prospect of our being able to complete the dilatation in this way, without resort to any cutting operation. The only check we have sustained is that his urine was neutral on Saturday, and to-day has become alkaline for the first time. When the urine becomes alkaline in these cases, the question always arises, what has caused it. Cystitis is the general cause, and the use of the catheter itself, in spite of all the antiseptic precautions taken with it, is not unlikely to produce it. In all these cases in which the catheter is fastened in the bladder, we use antiseptic bladder washes once or twice a day as a routine measure of prevention, but here it has come on in spite of this. In such cases, withdrawal of the catheter generally allows the cystitis to subside. We then pass the catheter once a day, wash out the bladder, and withdraw it again immediately. This nearly always produces a satisfactory result, and might be adopted from the beginning, but it is a much slower proceeding than fastening the catheter in.

The next patient, aged forty-nine, had a stricture of the urethra, which was being treated by dilatation. My house-surgeon had dilated up to a No. 8 catheter: but the day following this, matters went back again, and he could not get in any instrument at all. He has some old false passages about the urethra, which were made in attempts at catheterism outside the hospital. These false passages have become inflamed, probably from our attempts at catheterism, have swollen up, and so completely closed the channel. Therefore, the other day I performed a perinæal section, and

then passed a catheter along the whole course of the urethra. I often have attached to the plug in the catheter two or three inches of catheter wire, which tends to keep the catheter stiff and prevent it slipping out of the urethra, bellying out, we call it, because it bends out with a great convexity between the point where it is fastened and the meatus. If that is not done, the tape fastening the catheter should be tied very close to the meatus. The bladder is being washed out, and the urine comes away quite readily. The form of perinæal section we have adopted here, is what is known as Syme's urethrotomy, because under chloroform we were able to get into the bladder a Syme's urethral staff. The operation becomes in such cases very easy, because it is simply making an incision on to a groove in a shouldered staff. In this operation a linear section is made through the stricture for a distance of about two inches, and a large catheter at once is introduced, so that the stricture does not contract again. Besides that, the drainage from the perinæal incision allows time for the false passages to get quite well.

It should be observed that I do not generally advise dilatation of a urethral stricture by instruments in cases where false passages are known to exist. Perinæal section is in these cases very much better treatment; but my dressers and house-surgeon commenced the dilatation as routine treatment before I saw the patient, and did not themselves know of the existence of the false passages until difficulties were met with, when the patient confessed that he had been in trouble in this way some twelve months previously.

The third case is a man aged forty-one, who also has had Syme's urethrotomy performed, and we fastened a catheter in the perinæum. This was rendered necessary because the urine was so very thick and foul, that I thought perinæal drainage would be best for the patient for a few days. But after the operation some gradual oozing of blood took place into the catheter, gradually blocking it up, so that the drainage from the bladder does not now take place effectually. In addition rather a large mass of dressings was used to exercise pressure on the perinæum and stop the oozing, so that probably the catheter has slipped a little out of the bladder. When there is no hæmorrhage from the perinæal wound or after the oozing has ceased, I often treat these cases without any dressings at all, because the wound is very small, and if it is kept pretty frequently cleaned and washed there is no necessity for them. We can regulate the length of the catheter then very much better. When I take this catheter out you see that it is coated with a very considerable amount of phosphate, even though it was only put in three days ago. This is due to the very foul and ammoniacal condition of the urine. I will now pass another new catheter and we will wash the bladder out thoroughly, and only use a couple of thicknesses of boracic lint against the wound, and we shall not then have a great mass of dressings to drag upon the catheter. I expect that it will drain properly now that there is no blood-clot in it.

Here is a man just admitted, fifty-three years of age, who complains that when exerting himself he has a pain in his perinæum and under his scrotum. On questioning him we find that his water sometimes stops suddenly while micturating, and that after doing hard work he passes small specks of blood, which do not float but are entangled in mucus. He also frequently has pain at the meatus urinarius while micturating. The urine is of a light colour and not offensive. He has been complaining of these symptoms for the last four or five months. All these symptoms, as you know, point to stone in the bladder, and he tells us that he has already had one stone removed, two years ago, by the supra-pubic method; of this we can see the scar. His prostate is also a little enlarged on the right side. You know that there are various forms of stone found in the bladder; the three commonest are oxalate of lime or mulberry calculus, uric acid either free or in combination with soda or ammonia, and the triple phosphate calculus, *i.e.*, the phosphates of ammonium, magnesium, and water. To make a diagnosis of the nature of a stone before it is extracted is generally a matter of considerable difficulty; you have only the hardness and the size of the stone, as well as some indications derived from the condition of the urine and from the history of the patient, to go by. On introducing the sound I found that the stone is felt with difficulty, *i.e.*, it is lost sometimes and then felt again, so it is not of large size, probably about half an inch in diameter. Next we have to take into consideration the softness of the stone, which is judged by the ring and by the sensation which it communicates to the sound. There are three varieties of ring which you get: first, a ring almost as distinct as that produced by striking one metallic body with another; secondly, one less distinct than this, but still very recognisable; and thirdly, one which is hardly perceptible. Notice that we have here a stone of medium hardness;

this is in favour of its being a urate. The duration of the symptoms also tends to confirm this. An oxalate is usually of slow formation, and produces symptoms early, from its hardness and the rough tuberculated character of the surface. Four or five months' history would be a short one for a calculus of this size. He has had, too, very little hæmorrhage, whereas oxalate stones generally produce more. Both these last observations, however, are subject to many exceptions. You will notice also that the urine which came away while I was passing the sound was quite clear and acid, a point very much against the likelihood of the existence of a phosphatic stone. Hence I expect we shall find it is a uric acid or a urate calculus.

[*Note.*—This calculus was extracted a day or two later by the supra-pubic operation, and proved to be a uric acid calculus, about five-eights by three-quarters inch in diameter. The patient made a very rapid recovery.]

Hospital News.

CLASSIFIED LIST OF CASES.

"Clinical."

John	1.	Pneumonia and pleurisy.
	2.	Cerebral hæmorrhage.
	3.	Gastric atony.
	4.	Typhoid.
	6.	Pericarditis.
	7.	Typhoid.
	8.	Appendicular abscess. Operation.
	9.	Lardaceous disease.
	10.	Disseminated sclerosis. Fibroid lung.
	11.	Sub-diaphragmatic abscess.
	12.	Old appendicular abscess. Operation.
	15.	Acute Bright.
	16.	Leucocythæmia.
Miriam	17.	Broncho-pneumonia.
	18.	Mitral stenosis and regurgitation.
	20.	Typhoid.
	21.	Pericarditis and aortic disease.
	22.	Mitral regurgitation and stenosis. Aortic regurgitation.
	23.	Pelvic tumour. Operation.
	24.	Cerebral tumour.
	25.	Subdural abscess. Operation.
	26.	Typhoid.
	27.	Acute hydronephrosis. Operation. Removal of kidney.
	28.	Hemiplegia and aphasia.
Miriam	29.	Pericarditis.
	30.	Gastric ulcer. (Suppurating parotid).
Cot	33.	Broncho-pneumonia.
	35.	Pyrexia. Temperature 105·8°.
	36.	Marasmus.

In the Surgical Wards.

Cases under Mr. Howse.

Naaman	4.	Overgrowth of fibula and separated tibial epiphysis.
	7.	Osteoma of skull.
	8.	Carcinoma recti. Colotomy.
	12.	Empyæma.
	13.	Stricture of urethra. Cystitis.
	15.	Epithelioma of penis. Amputation.
	18.	Talipes equino-varus. Tarsectomy.
Dorcas	1.	? Gonorrhœal arthritis (wrist).
	4.	Lupus of face.
	6.	Movable kidney.
	11.	Stricture of rectum.
	15.	Injury to spine (paraplegia).
Astley Cooper	6.	Fractured humerus and ruptured urethra.
	27.	Compound fracture of jaw. Injury to foot.
Isolation Ward.		Post pharyngeal abscess (measles).

Cases under Mr. Davies-Colley.

Job	5.	Epithelioma of tongue.
	6.	Tertiary ulceration of nose. Rhinoplasty.
	13.	Impacted urethral calculus.
	20.	Strangulated inguinal hernia. Radical cure.
	22.	Strangulated inguinal hernia. Radical cure.
Lydia	4.	Myeloid sarcoma of tibia. Amputation.
	5.	Strangulated umbilical hernia. Kelotomy.
	7.	Scirrhus mammæ. Amputation.
	9.	Nævo-lipoma of foot.
	10.	Fractured patella.
	15.	Cut throat.
	16.	Mammary abscess.
Cornelius	8.	Scalp wound.
	13.	Concussion.
	15.	Depressed fracture. Trephined.
	17.	Compound fracture of tibia and fibula.

Cases under Mr. Lucas.

Martha	3.	Needle in knee-joint.
	4.	Cleft palate.
	7.	? Renal calculus.
	8.	Femoral hernia.
	9.	Tubercular wrist. Amputation.
	17.	Appendicitis.
	22.	Deflected septum nasi.
Cot D.		Tubercular knee.

Lazarus	7.	Tubercular knee. Excision.
	8.	Tubercular osteitis of clavicle.
	10.	Renal calculus.
	17.	Melanotic sarcoma in groin.
	20.	Inguinal hernia.
	21.	Varicocele.

Cases under Mr. Golding-Bird.

Luke	5.	Torticollis.
	6.	Tubercular ulceration of fauces.
	8.	Multiple gummata.
	9.	Epithelioma of bladder.
	12.	Inguinal hernia.
	13.	Stricture of urethra.
	14.	Ununited fracture of tibia.
	15.	Morrant-Baker's cyst.
	18.	? Cerebral abscess.
Charity	1.	Hammer toe.
	4.	Recurrent carcinoma mammæ.
	7.	Malunited surgical neck of humerus. Wired.
	8.	Tubercular knee.
	10.	Ranula.
	12.	Fractured patella.
	Cot A.	Spinal caries.
	Cot B.	Tubercular testis.
Cornelius	3.	Fractured femora. Wired.
	10.	Compound fracture of tibia and fibula.
Astley Cooper	20.	Low impacted, extra-capsular fracture of neck of femur.
	21	Lacerated hand. Evulsion of tendons.
	22.	Fractured femur.

Cases under Mr. Jacobson.

Naaman	21.	Inguinal hernia and retained testis.
Dorcas	19.	Compound palmar ganglion.
	20.	Enlarged semimembranosus bursa.
Patience	5.	Tubercular caries of inferior malleolus.

Cases under Mr. Symonds.

Job	13.	Vesical calculus and enlarged prostate Suprapubic lithotomy.
	14.	Inguinal hernia. Radical cure.
	15.	Gall-stones. Cholecystotomy.
	19.	Stricture of œsophagus.
Lydia	19.	Cleft palate.
	20.	Appendicitis. Appendicectomy.
	21.	Tubercular wrist.
Ruth	35.	Tonsillar hypertrophy and adenoids.
	36.	Deflected nasal septum.
Samaritan	7.	Diffuse infective periostitis.

Cases under Mr. Lane.

Lazarus	11.	Talipes equino-varus.
	12.	Appendicitis.
Martha	10.	Double congenital dislocation of hip.
	11.	Movable kidney.
Patience	Cot C.	Pyæmic arthritis.
Samaritan	11.	Tertiary syphilitic ulceration of elbow.

Cases under Mr. Dunn.

Luke	1.	Inguinal hernia.
	2.	Undescended testis.
	4.	Renal calculus.
Charity	21.	Carcinoma mammæ.
	22.	Femoral hernia.
	23.	Abdominal tumour. ? Colon.
Patience	4.	Axillary abscess.
Samaritan	7.	Gangrenous stomatitis.

Report of the Council of the Hostel Children's Home, "The Haven."

In presenting their report to the Subscribers, the Council of the Hostel Children's Home think that it may prove of interest to many of those present at the meeting if they preface their statement with a short account of the reasons which induced the Treasurer and Governors of the hospital to establish the Hostel for Laundresses upon its present basis about five years ago (June, 1894). At that time and for many years previously, much difficulty had been experienced in obtaining the services of women at once honest and capable in the laundry of the hospital. It was therefore thought expedient that the laundresses, instead of being drawn from the outside should live within the precincts of the hospital, and for this purpose a convenient building was acquired for £2,100, a further sum of about £1,500 being spent upon alterations and furnishing. It was decided that the staff should be taken from the class of young women who, "more often from ignorance than deliberate intention, have fallen from the way of right living," and upon these lines the Hostel has continued to be conducted. It may at once be said that under the watchful supervision of the Matron and through the unremitting care of the Hostel Mistress, Nurse Evans, together with willing help from other friends and sympathisers, the scheme thus initiated has fully justified the hopes of those who promoted it.

With wider experience of the peculiar difficulties of the undertaking, the conclusion has been reached that the class best suited to the mild discipline and comparative freedom of the Hostel, are young women with first babies anxious to redeem their characters, and ready to work steadily that they may earn money for the support of their children. It is indeed felt by those competent to form a just opinion, that the tie between mother and child affords the strongest incentive to the parent in her struggle towards better things, and that for this reason it is most desirable that the mother should have her infant so near, that by frequent visits and personal service she may keep alive the warmth of her affection, and watch over the welfare of her child. Here, however, the difficulty at once arose of finding within any reasonable distance of the hospital, respectable homes in which the children could be nursed and tended for the five shillings a week, which was all that the mothers could afford, nor, when such homes were found, was it wise to ignore the

dangers to the mothers in allowing them to visit their infants in such surroundings as are to be found in the Borough, and perchance amidst the undesirable associations of the life they have left.

It was to meet these difficulties that in September of last year the Matron set about raising funds for the establishment of a children's home in connection with the hostel, and, as the list appended to this report shows, with the gratifying result that no less a sum than £931 15s. 5d. has been raised towards the £1,200 required on capital outlay.

In May of the present year the first meeting of subscribers was held, at which it was "agreed that it is desirable to provide a home in connection with Guy's Hospital for the reception and maintenance of the babies of the women employed in the hostel and elsewhere in the hospital, and of such other children as the authorities of the home may think fit to admit." It was further resolved to purchase a freehold house, known as "Shelford." 182, Devonshire Road, S.E., for the sum of £950, and the Treasurer suggested that it would be best for the house to be purchased in the name of the President and Governors of the hospital for the purposes of the contemplated home, and that it should be leased to Miss Nott-Bower and others with the following stipulations:

The yearly rent of the house to be calculated at 3 per cent. on the unpaid balance of the purchase-money, and if the whole sum be raised, the house to be leased at a peppercorn rent.

The house to be used as a charitable home for the reception and maintenance of the infants of women employed in the laundry or elsewhere in Guy's Hospital, and for such other children as the council of the home may see fit to admit.

The Court of Committees to be requested to place upon their minutes a resolution to the effect that, so long as the house should continue to be used to their satisfaction as a home for the purposes above-mentioned, the Governors considered that good faith to the original subscribers required that their successors should renew the lease upon similar terms.

As regards the management of the home the meeting passed the following resolutions:

The subscribers to meet annually for the purpose of electing the council; the council to meet as required from time to time, and to issue the annual report, and to elect the executive committee, consisting of not more than seven members.

The first executive committee was formed by Miss Nott-Bower, Miss Esther Young, Mrs. Chas. Fagge, Mrs. Roffey, Miss Brereton, and Miss Hogg. Under their direction the furnishing of the house has been carried out, and it has been thought convenient that it should be known as "The Haven."

It is arranged that the mothers of the children shall contribute five shillings a week for their board, the balance required for the maintenance of the home being raised by annual subscriptions. It is calculated that with eight children a sum of £100 per annum will be needful, and towards this rather more than £20 is already promised. The council have, therefore, to appeal for further help, particularly from ladies interested in the work.

The children of the home will be brought up under the care of a home-mother of the domestic servant class, and when old enough will be sent to the Board Schools in the neighbourhood. The girls will be trained for domestic service, and the boys for useful occupations.

In conclusion, the council have to express their hearty thanks to the Bishop of the Diocese for coming down to open the home, and for the constant interest taken by himself and Mrs. Talbot in a scheme which they confidently trust will prove of far-reaching benefit to the hospital and the community at large.

GUY'S HOSPITAL CHILDREN'S HOME.

Statement of Capital Outlay upon the purchase and furnishing of the freehold house, "The Haven," 182, Devonshire Road, Honor Oak Park, S.E.:—

	£	s.	d.
Cost of Freehold	950	0	0
Fixtures, repairs, and legal expenses ...	60	14	10
Estimated cost of furniture, etc.	189	5	2
	£1,200	0	0
Towards this amount donations have been received or promised, as per attached list, of	931	15	5
Leaving a balance required on initial expenditure of	268	4	7
	£1,200	0	0

DONATIONS RECEIVED TO DATE (OCTOBER 30TH, 1899).

	£	s.	d.
Alfred Beit, Esq.	100	0	0
Everard Hambro, Esq.	100	0	0
H. Cosmo O. Bonsor, Esq., M.P.	50	0	0
Alfred L. Cohen, Esq.	50	0	0
Robert Gordon, Esq....	50	0	0
J. Herbert Benyon, Esq.	50	0	0
J. Pierpoint Morgan, Esq.	50	0	0
Sir Frederick Wigan, Bart.	25	0	0
Robert Barclay, Esq, ...	25	0	0
Rodolph A. Hankey, Esq.	25	0	0
Hugh Colin Smith, Esq.	25	0	0
J. A. Shaw-Stewart, Esq....	25	0	0
Sir Frederick Wills, Bart.	25	0	0
Rt. Hon. Lord Ashcombe	25	0	0
Per Nurse Roffey	25	10	0
Henry Lafone, Esq.	20	0	0
F. A. Lucas, Esq.	20	0	0
M. T. Martin, Esq.	20	0	0
Rt. Hon. Lord Aldenham	10	10	0
Miss Esther Young	10	10	0
Miss F. Nott-Bower	10	10	0
John S. Gilliat, Esq., M.P.	10	10	0

	£	s.	d
Mrs. Roffey	10	0	0
Hon. Mrs. E. S. Talbot	10	0	0
F. H. Norman, Esq.	10	0	0
R. M. Harvey, Esq.	10	0	0
Frank Debenham, Esq.	10	0	0
Hon. Evelyn Hubbard, M.P.	10	0	0
Rev. W. Stanton	10	0	0
Hon. Walter Rothschild	10	0	0
Sir C. T. Dyke Acland, Bart.	10	0	0
Herbert Raphael, Esq.	10	0	0
Miss M. Young	5	5	0
Charles Barclay, Esq.	5	5	0
Messrs. Wernher, Beit & Co.	5	5	0
Hon. E. Hucks Gibbs	5	0	0
E. H. Lushington, Esq.	5	0	0
Rt. Hon. Lord Cottesloe	5	0	0
Charles Hoare, Esq.	5	0	0
R. E. Johnston, Esq.	5	0	0
H. Williams, Esq.	5	0	0
Miss Puckle	3	10	9
Mrs. Gibbins	3	3	0
Mrs. Thompson	2	8	2
Miss Gordon	2	2	0
Mrs. Ricardo	2	2	0
Miss Alexander	2	2	0
Mrs. Wharrie	2	2	0
Mrs. Fremantle	2	0	0
Professor Bower	2	0	0
H. M. Bower, Esq.	2	0	0
Mrs. Wethered	1	1	0
Hon. Lady Fremantle	1	1	0
"B."	1	1	0
Miss Bunton	1	1	0
Miss Young	1	1	0
Miss Hilton	1	0	0
Lady Katharine Manners	1	0	0
Miss White	1	0	0
Miss Ogilvie	0	10	6
Miss Irving	0	15	0
Mrs. Lawrence	0	5	0
Mrs. Green	0	5	0
	£931	15	5

ANNUAL SUBSCRIPTIONS PROMISED TO DATE (OCTOBER 30TH, 1899).

	£	s.	d.
Miss Stanton	5	0	0
Mrs. Charles Barclay	2	2	0
Miss E. Young	2	2	0
Miss F. Nott-Bower	2	2	0
Mrs. Mann	2	2	0
Miss Puckle	1	1	0
F. G. Nott-Bower, Esq.	1	1	0
Capt. Nott-Bower	1	1	0
Mrs. Perry	1	1	0
Mrs. Wells	1	1	0
Miss M. Young	1	1	0
Miss Cotton	1	0	0
Miss Easton	1	0	0
Miss Evans	0	10	6
Miss Maw	0	10	6
Miss Smith	0	10	0
Miss Iles	0	2	6
	£23	7	6

By order of the Council,

October 30th, 1899. E. C. PERRY, Secretary.

Pupils' Physical Society.

THE ROENTGEN RAYS AS A MEANS OF DIAGNOSIS.

By Messrs. A. H. B. KIRKMAN and E. W. H. SHENTON.

MR. PRESIDENT AND GENTLEMEN,—Before giving you a practical demonstration of the application of the Roentgen Rays in medicine, we propose, with your permission, to briefly point out the everyday uses of this valuable instrument of diagnosis. We prefer to regard the Rays as an instrument of diagnosis rather than consider radiography as a special branch of medicine.

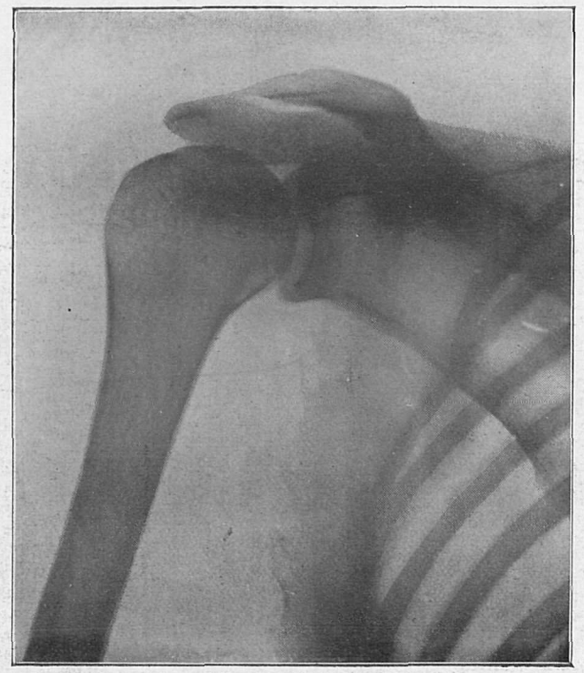
As the stethoscope is to medicine, so is the X-ray apparatus; it is another means whereby we may ascertain the conditions beneath the surface.

Radiography is supposed by some to be a special branch of photography; this cannot be allowed unless it is also admitted that auscultation is merely a branch of acoustics or bacteriology a branch of cooking.

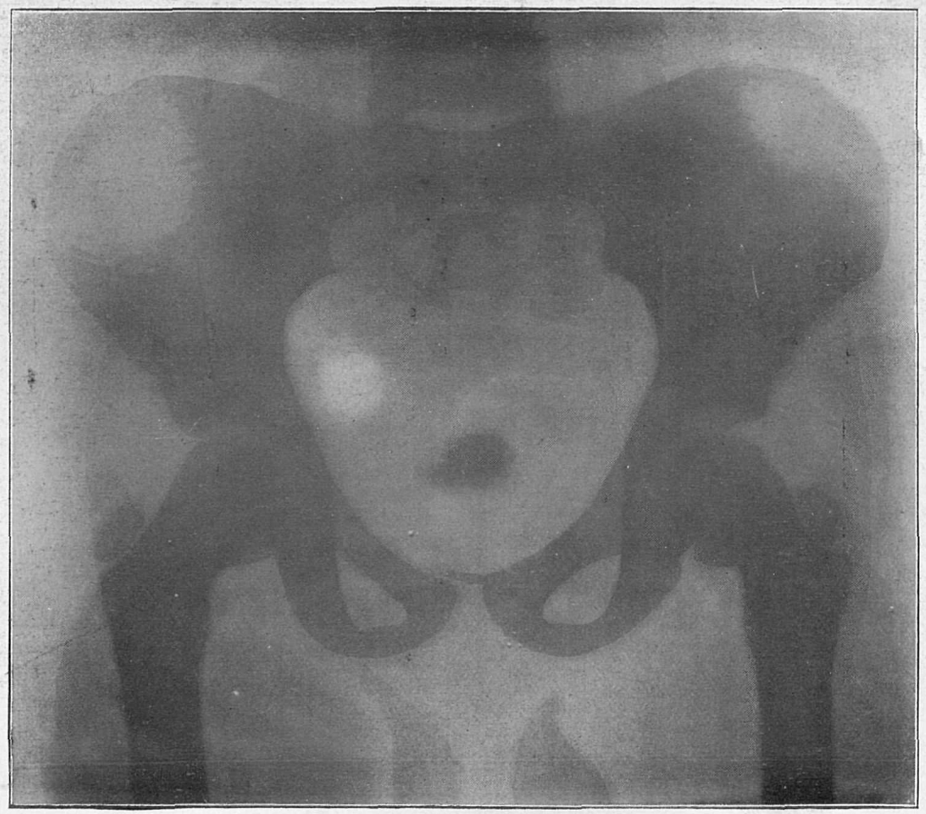
A certain therapeutic value is attributed to the Roentgen Rays, but for want of sufficient evidence to bring before you we will not to-night discuss the subject. We will confine our attention to the uses of the Roentgen Rays as a means of diagnosis.

In the detection of bone lesions the value of this instrument cannot be over-estimated when combined with other surgical methods. Here let me mention the importance of making a physical examination first. If you agree to accept radiography as a means of diagnosis you must use it as you would use any other means. You must not divorce it from such methods as inspection and palpation. It is by so doing that the Roentgen Rays have earned a reputation for misrepresentation. You do not expect your stethoscope unaided to make a complete and finite diagnosis, and you must not expect the much less understood X-ray instrument to do so either.

One often hears said reproachfully that the fluorescent screen and photographic plate are replacing other means of examination. Perhaps no greater compliment could be paid to this new method—painless and free from risk as it is, but we feel the tribute is unjust. Radiography does not seek to replace the medical man but to be his servant. We have prepared a few lantern slides of some



NORMAL SHOULDER JOINT.



VESICAL CALCULUS.

RIGHT RENAL CALCULUS.

Reproductions of Skiagraphs, illustrating Messrs. Kirkman & Shenton's Paper on "The Roentgen Rays as a means of Diagnosis."

everyday cases in which the Rays have been of value. The want of extreme definition in the originals, which are of course only shadows—not images focussed with a lens—makes the appearance on the lantern-screen a little disappointing, but as diagrams they will serve to illustrate interesting points.

SLIDE No. 1 (the bones forming the elbow-joint seen from before backwards. The skiagraph is from a young boy, and the epiphysial lines are peculiarly ragged and might easily be mistaken for fracture).—Had no physical examination been made in this case, it is probable that injury to the lower end of the humerus would have been suspected. This, however, was the sound arm and was taken to compare with the one of the opposite side which had sustained injury. It is conceivable that such a skiagram might be the cause of trouble from a medico-legal point of view.

SLIDE No. 2 (left foot showing tarsal and metatarsal bones). The base of the fifth metatarsal bone has been broken off—a rather rare fracture. The patient, a man of 45, slipped from the curb, twisting his foot under him. Three weeks later he was complaining of severe pain along the outer side of his foot; he had, I believe, been walking about ever since the accident. Such a condition as this skiagram shows was not one among the many suggested by his medical advisers.

SLIDE No. 3 (dislocation of ulna and radius backwards, seen from the side). This case was examined and skiagraphed within ten minutes of the occurrence of the accident to see if the dislocation were complicated with fracture. The small chip of bone is evidently the coronoid process of the ulna.

SLIDE No. 4 (bones forming elbow-joint).—In this picture may be seen a marked thickening of the lower end of the humerus. The patient, a girl aged 19, had various signs of tubercle about her. The case was considered one of tubercular periostitis. In the diagnosis of tubercle in or around bone the X-rays are of extreme value. As an example of tubercular disease of joints we have here the skiagram of a knee. The erosions of the bony surfaces are quite easy to make out. One observer has called attention to the ease with which tubercular joints may be diagnosed by the X-rays. He speaks, however, of the erosions of the cartilage being demonstrable by the rays. Here I do not agree with him. I have repeatedly endeavoured to show the cartilages of the knee but have not been successful, though in one case the synovial membrane showed well. As cartilage does not show, it seems unlikely, then, that erosions of cartilage will either. This case of tubercular knee-joint, we might add, was diagnosed in the skiagraph department, the case until that time being considered a traumatic arthritis. The joint was subsequently excised. In connection with tubercle we might mention the ease with which phthisis may be detected. Consolidated lung has been estimated to be ten times more opaque to the X-rays than healthy lung. It seems possible that phthisis may be detected earlier by these means than by any other. Dr. Williams, of New York, says, "I have yet to see the case of incipient phthisis that cannot be accurately diagnosed by the X-rays." Allowing a suitable margin for the Western Hemisphere, and for individual enthusiasm, it must still be admitted that the subject is well worth investigating.

SLIDE No. 5 (leg from before backwards).—There is a greenstick fracture of the tibia. This was taken a few weeks after the accident—the ensheathing callus is evident.

SLIDE No. 6 (leg and knee from before backwards).—An old injury to the tibia can be seen. The patient was an old Guy's man. Some years ago he fell from his bicycle and dislocated his knee, fracturing, it was said, both bones of the leg. We do not think the fibula has ever been broken. The non-existence of a fracture is often demonstrated by the X-rays. As an example I might mention the case of a young lady who had two accidents to her forearm within a few weeks of one another. The first injury sustained was said to be a fractured ulna; the second, fractures of both bones of the forearm. Splints were of course applied, and the medical man gained great credit for the successful setting of the bones. We have most carefully examined the forearm by the Rays, and feel confident that neither ulna nor radius have ever been broken.

SLIDE No. 7 (transverse fracture of patella seen from the side).—This case needs no comment.

SLIDE No. 8 (leg and foot seen from the side).—An extensive formation of callus at the site of an old fracture at the lower end of the tibia caused great pain. The X-rays in this case cleared a suspicion of sarcoma from the air. The callus was subsequently removed by operation. The usefulness of the X-rays in the detection of foreign bodies is universally recognised. The most common everyday example is, of course, the needle in the hand.

SLIDE No. 9 (hand from before backwards).—This picture represents such a case. A piece of needle is seen opposite the head of the third metacarpal bone.

SLIDE No. 10 (knee, side view). This represents a needle in the knee, probably in the patella tendon. To extract a needle with the aid of a skiagraph above is no easy matter, and one which we should advise no one to attempt. It is imperative that some method of localization should be employed in every case. There are various ways of estimating a needle's exact depth; the one which appeals to everyone is to take two pictures from points of view at right angles to one another. In certain cases this is of value, in the majority it is useless. Dr. Mackenzie Davidson's method, in which two views are taken on a special piece of apparatus, is a very scientific and exact method of localisation; but the time, patience, and material required render it suitable for the occasional case only. It would be impossible to treat all the cases of foreign body at this hospital by Mackenzie Davidson's method, and have time to do anything else. The stereoscopic method which Dr. Mackenzie Davidson has worked

at is extremely beautiful, but its employment as a routine practice is entirely out of the question. The system of localization which we use in this Roentgen Ray department, and of which I have published a detailed description in the last issue of "The Archives of the Roentgen Ray," is briefly as follows:—

We will suppose for the sake of simplicity that the case is one of needle in the hand. The hand is placed in contact with the fluorescent screen, and the tube so adjusted that the surface of the anti-cathode is parallel with the surface of the screen. When the needle is clearly visible, the screen and hand are swayed from side to side. Bones and needle will be seen to move across the screen, and the relative rates at which they move is the key to the depth of the needle. If the needle is quite superficial—that is, close to the screen surface—its image moves a shorter distance in the time than the images of the bones. A little practice enables one to give a very accurate estimate of the needle depth. The advantages I think I may claim for this system are:—

Firstly.—The dispensing with any special form of apparatus.

Secondly.—The saving of time. The process need not take more than a few seconds.

For thicker portions of the body and for parts less easily manipulated, Mr. Dean, of Hatton Garden, is constructing me an instrument. The tube in this case is swayed while the part under examination remains stationary. There will be arrangements for making the minutest calculations for those who have the millimeter scale and where it is impossible to see the foreign body on the screen the photographic plate can be utilized. As an example of a difficult case for localization by every method, I will quote that of an adult woman who swallowed a packing-needle. The needle was proved by this oscillating method to be in the descending colon, and this without the involvement of any photographic process.

Slide No. 11 (Head, side view).—This picture shows a bullet in the head, as seen from this point of view it is about two and a half inches from the frontal bone on a level with the supraorbital ridge. Looking at the head antero-posteriorly it could be seen three-eighths of an inch from the middle line on the right side. It entered through the frontal bone.

Slide No. 12 (A skull, side view).—This represents a sagittal section of a skull with the bullet on the end of a piece of wire, so arranged as to correspond in all proportional measurements with the position of the bullet in the last picture. It may be interesting to state here that many of the early skiagrams adorning the windows of photographers' shops were taken, as this was taken, from the dried bones. A manifestly easier process than where allowance has to be made for other tissues. This was the cause of a deal of unhappiness in the skiagraph department, for friends would be continually saying, "Why don't you turn out skiagrams like so-and-so? his do slightly resemble bones, but yours are more like London fog," and other remarks of a similarly unkind nature.

Slide No. 13 (ribs and piece of dorsal spine).—This skiagram shows a bullet in the chest. The case is of special interest. The patient is E.P., Case II. in Mr. Douglas' paper, published in the *British Medical Journal* October 21st, 1899. The best known among skiagraphists have done their utmost to find the bullet. On account of their non-success, Mr. Douglas argued that though the man had blood-stained sputum, possibly the lung had not been penetrated. While screening with a red tube we could distinctly see the bullet in the lower lobe of the right lung, moving some inches during respiration. We believe this wide range of movement prevented the bullet showing at all on a negative. This skiagram was secured while the patient held his breath.

Slide No. 14 (a pelvis from before backwards).—This skiagram shows a calculus in the bladder. The patient is young as you may see by the epiphyses. The stone was removed by the suprapubic operation. It consisted of alternate layers of uric acid and oxalate of lime.

Slide No. 15 (lower ribs and lumbar vertebræ).—Here may be seen a renal calculus *in situ* in the left kidney. The history of the case is interesting. Three years ago the patient had all the usual symptoms of renal calculus in the left side. The kidney was explored with a negative result; since that time the patient has suffered continuously with attacks of paroxysmal pain followed by hæmaturia. After the demonstration of the calculus by the Roentgen Rays Mr. Lucas explored the kidney, and after a prolonged search found the calculus hidden away in one of the calices. The composition of the stone has not yet been ascertained. The few remaining slides we wish to show you are taken from normal cases. They will, we believe, suggest to you many possibilities in the way of diagnosis.

Slide No. 16 (A knee-joint, side view).—It is worth noticing how far up the shaft of the femur the patella lies, it is usually depicted as lying opposite the joint in the extended position of the limb. Here you will notice it lies a good way above the joint, and this though the knee is not fully extended.

Slide No. 17 (An elbow-joint, side view).—This position would show well anterior and posterior dislocation or a fractured olecranon process.

Slide No. 18 (An elbow-joint, from before backwards).—The clear line beneath the olecranon process should be noted as it has led more than once to the diagnosis of fracture.

Slide No. 19 (The bones of the forearm).—This same line shows again in this picture.

Slide No. 20 (A thorax).—This is the last we have to show you. It was taken while the patient held her breath; the exposure was one minute. The scapulæ are outlined and their spines are very easily distinguished. A very interesting feature is the outlining of the vessels radiating from the roots of the lungs—this appearance has not been called attention to before to our knowledge.

Passim.

The new method of appointment of extension dressers came into force last month, and in the present list one dresser from each surgeon's firm has got extension, not necessarily the four best men in absolute order of merit. The result has caused great disappointment to the men who have been passed over, and it is acknowledge by those in authority that an injustice has been done to them. However, the scheme is an attempt on the part of the Medical School to make the work in the various departments of the Surgical side more even, and is aimed at the eventual benefit of all. While the scheme is on trial, as it is, criticism is both uncalled for and unjust; and the change must be judged by the results. Meanwhile it is to be hoped the authorities will not forget to reward in the near future the men who, through no fault of their own, have been disappointed now.

On Monday last, "The Haven," the house at Honor Oak for Children in connection with the Laundry Hostel was opened by the Lord Bishop of Rochester. Five infants were admitted, and the work of "The Haven" commenced in earnest. As will be seen in the column of Nursing Notes, the important announcement has been made that the institution will be managed by lay helpers quite unconnected with the Guy's Hospital Nursing Staff.

The accommodation in "The Haven" is fairly extensive. There are four bedrooms on both the upper and first floors, with bathroom, and on the ground floor there is a good entrance-hall, two large sitting-rooms, kitchen, scullery, etc. So there is evidently room for more children yet before it reaches its maximum of utility.

The Bishop of Rochester made a very sound speech at the Conversazione, concerning the duties of medical men. He pointed out that though a doctor's life is the highest of professions, there was always the danger of narrowness of mental outlook to be avoided. One is rather apt to consider one's own work and one's own hospital the centre of the universe, and many would be wiser men if they would go out into the world and look around and realize that there are hundreds of others at other places doing as good, if not better work than they. A pilgrimage to some of our sister hospitals with an open mind would much improve the work of many of us.

And while on the subject of the duties of medical men we would mention that the addresses which are shortly to be given in the Hospital Chapel are not really lectures on the conduct of medical men given by those outside the medical profession. They are rather, as the Chaplain puts it, addresses on the "Religio Medici," a far wider outlook. The only danger appears to us to be that by too much talking men may be made self-conscious of their profession, good as it is.

A man takes up the medical profession, to speak honestly, in ninety-nine cases out of a hundred to make a living, not to pass a life of absolute altruism. Therefore his duty is simply the duty of other men, to be honest and to be charitable when occasion may offer.

The best short description of a man's ideal in life is given in the following passage from R. L. Stevenson, the passage engraved on his monument in San Francisco:—

"To be honest, to be kind—to earn a little more and to spend a little less, to make upon the whole a family happier for his presence, to renounce when that shall be necessary and not be embittered, to keep a few friends but these without capitulation—above all on the same grim condition, to keep friends with himself—here is a task for all that a man has of fortitude and delicacy."

A short while hence, when it was known that Dr. Perry was still going to keep on skin out-patients and Dr. Fawcett was newly-appointed assistant physician, it was feared that the latter might not have enough to do. His friends on the Council, however, have soon arranged for him. An extra day for medical out-patients, namely, Thursday, has been arranged, and will commence next week. To still further keep Dr. Fawcett busy, he has been appointed Sub-Dean. This will involve a good deal of work and an angelic patience, especially if the Dean sets him to reply to all the disappointed suitors after each quarterly appointment list.

As this is the last occasion before the event, we would again remind all men, both at the hospital and away, that the Smoking Concert will take place on Saturday week, November 18th. A large number of the Staff have signified their intention of being present, and

even at this early date an excellent programme has been arranged. The only thing left to do is for all men to buy tickets.

A GREAT deal of nonsense has been talked in the daily press concerning the departure of certain eminent surgeons for the war, and the benefits that will accrue to the aseptic treatment of wounds upon the battlefield. It is a splendid thing that surgeons of such high repute are going out, but it must be evident that the battlefield of all places is one most unsuitable for aseptic surgery; it is one of the most urgent occasions for antisepsis, and thorough antisepsis too, for in the rush and hurry many men will not get really attended to and operated upon till after their journey to the base hospitals, in some cases hundreds of miles away. The tremendous amount of gush in the lay papers over such an ordinary procedure as the departure of well-known civil surgeons to the seat of war rather inclines to make one ashamed of the whole business.

W. R. CAZENOVE has now left the hospital, unfortunately, we fear, for good, and is settled down as Assistant Medical Officer at the Northampton Lunatic Asylum. No man of his time will be more missed than he; a good musician, a comedian, an excellent *raconteur*, and above all a good companion, he was the life and soul of all entertainments both inside the hospital and outside it for its benefit. It seems a pity that his many real services for the hospital could not have been more solidly rewarded by the powers that be, but we suppose they know their own business best. Christmas this year will miss him sadly.

THE Debating Society's meeting on Saturday week last was a great success. Dr. Pavy, with his usual good nature, came down to preside, and for over two hours placidly sat aloft in an atmosphere of great heat, and which must have contained at least fifty per cent. of organic impurities. It was a hopeful sign to see how many men wanted to speak, and how keen everybody was on the subject; but politics are always an unfailing draw, and politics *plus* patriotism could not fail to succeed. As far as we see this year, the really humorous speaker is to seek.

THE Contemporaries Club have decided to hold their annual dinner this year on Friday evening, November 17th. It has been arranged on this date—the evening before the smoking concert—in the hope that men who have now left the hospital may manage to come up from the country and put in both evenings running. We are requested to ask all men who wish to come to the dinner to send their names and recent addresses to the secretary, Mr. W. L. Baker.

IN current literature this week, there are two articles of special interest to medical men. In the *Century Magazine* there is the commencement of a new story by Dr. Weir Mitchell, "The Autobiography of a Quack." Dr. Weir Mitchell's medical reputation is sufficiently world-wide to prove to all that here at last is a medical story by one well qualified to write it. The opening chapters do not belie one's hopes. The biting irony of the quack's history of his life is one of the best pieces of technical fiction we have lately read. The other, by way of contrast, and is a very humorous account of an operation in last week's *Black and White*, by Mr. Barry Pain.

THE hospital is the poorer to-day by reason of the departure of Sister Christine, for we can ill afford to lose such a successful innovator and administrator in this critical but conservative place. Sister Christine first entered Guy's some six years ago as a lady probationer. She subsequently went to the Shadwell Hospital as a nurse, and returned to Guy's on being appointed night sister. As sister in the out-patients—the most difficult department in the place, by reason of the complexity of the interests of the various people working there—she threw her whole soul into the work, and unswervingly did her best for the department and the patients. The altered condition of Out-patients to-day is the highest tribute that can be paid to her. It is gratifying to note that her place will be filled by so able a person as Nurse Willes, late staff nurse in Out-patients.

BUILDING in the Park, on the site for the new Nursing Home, is proceeding apace, and during the last week workmen have been busy digging a deep trench from the corner of Clinical to the door of the Medical Buildings. This is the future subway for pipes from the Nursing Home to the central part of the Medical Building, and is not intended for a nurse's subway as was generally supposed. The nurse's subway, when completed, will go from underneath Cornelius ward near the bacteriological

laboratory. During the excavations a large quantity of human bones have been brought to light—probably buried from the dissecting-room in former days. It is a strange thing, but excavations in London always bring great numbers of remains to light. In digging for some of the earlier foundations of the new buildings, a number of apparently Roman jars were brought to the surface, and on them all were inscriptions which up to the present have not been deciphered. Any philologist who would like to try can see them in Mr. Wells' office.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Guy's Hospital Chess Club.

DEAR SIR,—May I use your columns to call the attention of all Guy's men who are interested in the game of chess to the fact that the club meetings are commencing next week? The club smoking-room has been kindly lent by the students' club, and meetings are held there every Wednesday evening at 8 p.m. till 10.30 p.m.

Matches will be played during the season, and a tournament will be held at the beginning of the year for Dr. Shaw's championship cup.

All men who can help in winning for Guy's the inter-hospital chess trophy, either in this or in future seasons, will be most heartily welcomed. Any member of the committee will be glad to take any name for membership. The subscription is 2s. 6d. annually, and an entrance fee of 2s. 6d.

May I also inform members that the club card is now in the secretary's hands?

Thanking you in anticipation,—I remain, sir, your obedient servant,

EDGAR FAULKS,
Hon. Sec. G. H. Chess Club.

Guy's Hospital,
October 17th, 1899.

[This letter arrived too late for publication in our last issue.—ED.]

Nursing News.

MATRON'S OFFICE.

The following appointments of head nurses have recently been made :—October 5th: Nurse Ransford, head nurse in Astley Cooper ward; Probationer M. Wood, head nurse in Miriam ward. October 9th: Nurse G. Reeve, head nurse in Queen ward; Probationer Spedding, head nurse in Dorcas ward; Nurse Lewis, head nurse in Cornelius ward; Probationer I. Johnston, head nurse in the Isolation ward; Probationer Scholfield to Bright ward; Probationer Tracy to Philip ward; Probationer Ellis to Out-patients.

The London Obstetrical Society held their quarterly examinations on October 2nd and 9th, two nurses entering from the hospital and four from the institution.

The names of the successful candidates were Nurses Stuart and Crampton (hospital), and Nurses Hackett, Tillott, Searle and E. Tubbs (institution).

We much regret to have to announce that Sister Bright (Miss Brereton) has been obliged to ask for six months' leave on account of serious family trouble. During her absence Sister Cornelius will be in charge of Bright ward, and Nurse Holman, recently appointed a probationary sister, will be in charge of Cornelius ward. The vacancy thus caused on night-duty will be filled by Sister Priscella (Nurse Harding) as temporary night sister.

Nurse Sutton left the hospital on October 30th to take up a Foreign appointment.

Metropolitan Asylums Board.

APPOINTMENT OF ASSISTANT MEDICAL OFFICERS.

THE Metropolitan Asylums Board invite applications for the appointment of 4 (possibly more) Assistant Medical Officers at their Fever and Smallpox Hospitals. The salary is £160 per annum during the first year, and, subject to the direction of the Hospitals Committee, £180 the second year, and £200 the third and subsequent years, together with the emoluments of board, lodging, attendance, and washing, subject to statutory deduction under the provisions of the Poor Law Officers' Superannuation Act, 1896. Candidates must be unmarried, must not exceed 35 years of age, and must be qualified by law to practise both medicine and surgery in England.

Printed forms containing further particulars may be obtained upon application to the undersigned, to whom they must be delivered by 10 a.m. on Wednesday 8th November, 1899.

(Signed) T. DUNCOMBE MANN,
Clerk to the Board.

Office of the Board,
Norfolk House, Norfolk Street, Strand, London, W.C.
30th October, 1899.

Chapel News.

MENTION has already been made in these columns of a series of lectures for Guy's men in the Chapel, at 5 p.m., on the following Monday afternoons :—

DATE.			LECTURER.
November	13.	...	Rev. Canon Taylor.
December	11.	...	George W. E. Russell, Esq.
January	22.	...	Rev. E. F. Russell.
February	12.	...	George W. E. Russell, Esq.
March	5.	...	Rev. Canon Gore.
March	26.	...	Rev. Canon Newbolt.

It will be seen that the first lecture will take place before the next issue of the GAZETTE. The general subject of the lectures is Religio Medici.

Nursing Notes.

"The Haven" was opened on October 30th by the Lord Bishop of Rochester. This is an undertaking that has been viewed with interest by the nurses; especially since it was declared to be entirely separate from the Nurses' Recreation Club House.

At present there is a mild panic amongst us, a report having spread that a probationer is to be placed there permanently; even, too, a rumour that strings may be given for "The Haven." All of which proceedings are naturally regarded with grave disfavour by those nurses who are anxious for a purely hospital training without extras.

We may, however, assure our readers that no nurse will be asked to undertake the charge of the babies or given the chance of gracefully refusing. For, though "The Haven" is under the supervision of the Matron, it is apart from the hospital and will be managed by lay workers.

In the nurses' sitting-room there is to be found the nurses' library (that is, as far as it has got), and it will be opened this week. Of all the books sent in—and there were over a hundred and twenty—only half a dozen were rejected. And for why? They would have had Mark Twain's highest praise, as the binding was good and the print excellent. But they were next of kin to "Queechy" and the "Wide, wide world" series.

The experiment of taking second-hand books is answering well. All are in really good condition. They were all labelled and catalogued one morning. An eye witness related that a far smaller percentage of labels was found sticking to the clothing, hair and furniture, and a bigger percentage on the books than is usual. This shows mind.

It had been arranged that a few of the nurses should take turns in giving out the books, but Sister Esther has kindly engaged a boy for six months, who will come for two hours daily, and save the trouble and worry of continually finding some one to do duty.

The ecclesiastic tea-fight was a great success —when we say a success we mean everyone was inclined to be very chatty and pleasant. The great ones were not too official. Of course, we had a little speech and two addresses, but that always occurs when there is a meeting with men in it, and can't very well be helped. The music was very nice, so were the refreshments. Perhaps it would be more polite not to make the latter remark, but we were constrained to on seeing the night nurses make a good breakfast off sandwiches, cake and ices. The sisters and nurses were asked to wear all their orders, which seemed to consist of some yards of ribbon garlanded round about their necks, but they looked most imposing.

The Bishop of Rochester at Guy's.

On Wednesday evening last, by the invitation of the Chapel Committee, all at Guy's were invited to meet the Bishop of Rochester in the Court Room. Invitations had been sent out to all the Staff, Governors, Nurses and Students, and as a result the rooms were very crowded. Among those present were Mr. Cosmo Bonsor (the treasurer of the hospital), Mr. Shaw Stewart, Dr. Galabin, Professor Reinold, Dr. Pavy, Dr. Fawcett, the acting Chaplains, the Matron and Assistant Matrons. The bulk of the assembly was made up of the Junior and Resident Staff of the Hospital, the Sisters and Nurses, and a large number of the men.

Proceedings commenced at 7.30, and, as the Bishop of Rochester did not arrive till past 8 o'clock, the time was occupied in taking tea and coffee. Conversation was stimulated by the occasional performance of vocal and instrumental selections. On the arrival of the Bishop,

Mr. Cosmo Bonsor introduced him to the gathering, and welcomed him on behalf of the Hospital and Chapel Committee. He said that he very well knew that everybody at the hospital, nurses and students alike, considered themselves overworked, but he had not the slightest doubt that the Bishop of Rochester was as hardly used as any of them, and his kindness in making time to come down among those working at the hospital was very highly appreciated. He could not speak too highly of the work the Bishop had done for the hospital, and the benefits which had accrued to it since he had taken the Chaplaincy. The appointment of two chaplains instead of one, and the more efficient performance of the work, were sufficient tributes to his success. In the name of all those present, as representing the hospital, he welcomed the Bishop most heartily.

The Bishop of Rochester, on rising to address the assembly, said that he was really in rather an invidious position. Though nominally Chaplain of the Hospital, he had been invited there that evening as a visitor; that very fact made it evident that he was really not doing quite all he ought to be, and that the proper persons to address the meeting were the acting chaplains, who did all the administrative work. Though the meeting was

a very bright and social function, he thought he would rather take the occasion to say a few words upon the graver aspects of hospital life. The high standard of efficiency of modern medicine benefited the workers in the hospital by its advantages, but they also suffered by its defects. As in modern medicine everything tended to specialisation, each unit in the whole community doing only his particular share, but doing it at a very high standard of efficiency, so people at the hospital were rather liable to take too narrow a view of life, and to forget the broader issues of hospital work and life at large. Taking the simile of a man making, continually making, one small component wheel of a complicated piece of machinery, he would remind them that if the man, however efficiently and accurately he made his own particular wheel, got into the narrow state of mind of only considering the wheel by itself instead of also grasping its relations to the machine as a whole, he failed in his work. So it was incumbent upon all working at the hospital—doctors, nurses, students alike—to avoid that error of considering their own especial work as of supreme and essential importance, and to help by their example to further spread abroad a high standard of conduct in life, and by their right living to further the spread of Christian influence. Of the medical profession and the profession of nursing, without cant he could say that no words of his would adequately express his admiration. It was one of the highest professions in the world, and the influence of both doctors and nurses could not be over-estimated. But at the same time it was a life which tried one's virtues sorely. Patience, a rigid standard of conduct and never-failing dignity were necessary amid all trying conditions of sickness and domestic sorrow, and he hoped all present would keep some such ideal in their minds. He had come to believe, and thought all broad-minded persons could not help having come to that same state of mind if they had thought about the matter at all, that the highest Christian ideals could be spread by all alike, not necessarily the chosen ministers of the Established Church, and he would, in conclusion, pray all of those present by their conduct in life to take their share in the furtherance of all Christian virtues and teaching.

Later in the evening, Mr. SHAW STEWART, one of the senior Governors of the Hospital, rose, and said that as an old friend of the Bishop's and as one who knew his virtues thoroughly, he would ask the audience to very heartily thank the Bishop of Rochester for coming to Guy's on that occasion. Mr. Stewart's words were greeted with great enthusiasm and applause, and the Bishop of Rochester again rose and thanked everybody for their kind welcome to him. In such a kaleidoscopic evening, where the audience was always changing, at the risk of repetition, he would again point out what an opportunity for good they all had in their work at this hospital, and he would urge them never to forget in their passage through life the highest ideals of Christian teaching.

Shortly after ten o'clock the Bishop took his leave and proceedings terminated.

During the evening a selection of music was performed by the Nurses' Choral Society, Miss Wyllie, Miss Spalding, Sister Christine, Nurse Daniells, and Messrs. Starling and Parrett.

Pass List.

Second Conjoint Examination, October, 1899.

C. E. Bartlett, J. C. O. Bradbury, J. B. Copland, C. H. Denyer, P. W. Hamond, A. W. Iredell, W. C. Lewis, A. P. Piggot, C. J. Pinching, H. L. Shelton, A. J. Urquhart.

First Conjoint Examination.

PART I.—CHEMISTRY AND PHYSICS.—L. Doudney, F. G. Goble, G. H. Reinhold, R. M. Wingent.

PART II.—PRACTICAL PHARMACY.—J. E. L. Bates, S. J. Evans, F. J. Felix Jones.

PART III.—ELEMENTARY BIOLOGY.—L. Doudney.

(Four Years' Regulations.)

PART II.—MATERIA MEDICA.—C. H. Gask, T. Morgan.

University of Oxford, October, 1899.

EXAMINATION FOR THE DEGREE OF M.D.

Harry Cooper.

University of Cambridge, October, 1899.

EXAMINATION IN SANITARY SCIENCE FOR THE DIPLOMA IN PUBLIC HEALTH.

J. H. Godson. C. A. Lumley. A. E. Porter.

Contemporaries Club.

THE annual dinner of the above club will be held on Friday, November 17th. The place to be announced later. The committee trust that all men belonging to the club will be present if they possibly can. The subscription is 6s., payable before the dinner. Men who know the addresses of any members of the club who have left the hospital are requested to communicate them to the honorary secretary in order that he may notify those members. W. L. BAKER, Hon. Sec,

Papers by Guy's Men.

The Clinical Characters of the Plague Epidemic in India. By Harold W. Bruce, M.B., B.S. Lond.—*Lancet*, 21st October.

The Infectivity of Malignant Growths. By J. W. Washbourn, M.D., F.R.C.S., and G. Bellingham Smith, M.B., F.R.C.S.—*Ibid*, 28th October.

Guy's Hospital Debating Society.

A MEETING of the Debating Society was held on October 18th, in the Smoking Room. Dr. Pavy took the chair at 8.10. There was a large attendance in spite of the dense fog prevailing that night.

The Secretary read the minutes of the last meeting, which were duly confirmed.

Mr. L. E. Stamm proposed a motion of which he had given private notice, but the President ruled that as it was a motion to amend the bye-laws, it was not in order and must stand over till notice had been given at a meeting. Notice was accordingly given.

Mr. S. HODGSON, on rising to move—"That the time has now come for the Abolition of the South African Republic"—was greeted with cheers. He plunged at once into the history of Cape Colony and pursued the historical side at some length. He gave reasons for the war both from history and the present crisis, and concluded an erudite speech amid cheers.

Mr. R. THOMPSON essayed to deal firstly with Mr. Hodgson, and secondly with the subject, "The Outlanders are the scum of the earth." He was interrupted several times on points of order, on which he never failed to score, and the audience who had hitherto listened with silent rapture (!) to the eloquence were roused to some momentary enthusiasm. The opposer's repartee was decidedly smart, and after a well-delivered, robust speech he closed with a history peroration which contained some reference to the Sands of Charrhæ, and the Forests of Arminius, where the forces of Imperial Rome were checked.

A pause ensued, and then Mr. F. G. GIBSON rose from the back to voice, though unprepared, what he was sure was the general belief of the house. He argued that the question was not one of Franchise or of Drifts, but of Paramountcy in South Africa (loud cheers). As an instance of Boer unfaithfulness he quoted the experience of an expert in refrigerating machinery, who had at great expense (guaranteed) gone out to the Transvaal and never been paid.

Mr. G. T. WRENCH, whose maiden effort was warmly received, spoke on the other side. His speech was decidedly promising, and we hope to hear more of him in the future, and trust he will take to shifting prepared sentences into speeches bearing on the direction of the debate and to more active polemics. He dealt with Mr. Chamberlain's apparent acquiescence in the Boer proposals.

Mr. GRIFFIN, also a new speaker, spoke in a confident manner, and we hope to hear him again. He dealt with the points at issue one by one, but must beware of becoming prosy and lengthy or the House will not listen so kindly again.

Mr. KITCHEN made the best speech of the evening in a pleasant voice and with a good delivery. With practice in debating and more courage in attack, he should make a good speaker.

Mr. F. W. Sime, Mr. A. E. H. Pakes, Mr. T. R. Beale-Browne, and the Secretary spoke.

Mr. H. W. BRUCE spoke from the Boer point of view.

Mr. EASON divided the Boer arguments into "Historical and Hysterical," and made a neat, compact, and sensible speech.

Mr. L. E. STAMM spoke with knowledge of his subject and referred to conventions.

Mr. T. G. STAMM spoke for the motion, affirmed our right to interfere, regardless of conventions, on behalf of oppressed subjects.

Mr. F. E. WALKER was reminded of the fable of the Wolf and the Lamb.

Mr. THOMPSON replied in his most fighting manner, dealing with several speakers and scoring chiefly on their comments.

Mr. HODGSON replied, and accused Mr. Bruce of reading Stead's Pamphlet. Mr. Bruce: "I deny it. I have never seen the book." Mr. Hodgson suggested Mr. Stead's "Use of Telepathy."

Mr. BRUCE: "Mr. Chairman, I deny that too." (Loud laughter). The motion was put and declared lost, but there voted:—

For the motion	36
Against	13

Several of the opposition did not vote.

Motion declared carried.

Mr. S. HODGSON proposed a vote of thanks to the Chairman, who responded in one of the characteristic speeches which are so well known and so popular with the Society.

The chief points were the solemnity of the audience and the repartees of a few individuals, while Dr. Pavy's rulings were invariably most happy. The total attendance was about sixty.

The next meeting will be on *December 4th.*

The Opening of "The Haven."

BY ONE WHO WAS THERE.

"YOU must have one of these Reports," said the Matron, handing me some sheets from a sheaf of papers she was holding, as I entered "The Haven" on Monday afternoon last.

Outside, the air was cold and damp from the torrents of rain that had only just ceased to fall, and a depressing kind of mist hung over Honor Oak Park. The whole aspect was one of suburban discomfort.

However, it did not seem to affect the various groups who arrived at Honor Oak Park by the 4.15 train from London Bridge, and who plodded cheerfully up the hilly Devonshire Road in quest of "The Haven," their spirits seeming quite impervious to the atmospherical depression.

Once inside, one forgot the mist and the growing twilight. All was light, warmth and brightness, and the curly-headed mite who was introduced as "the eldest daughter of the house," evidently considered

it a gala-day got up expressly for her entertainment. Neatly and prettily-dressed babies were greatly in evidence, and quite willing and ready to be made much of by the guests.

Tea was laid in the Children's Nursery, a bright, large, pleasant room, with a most fascinating picture paper on the walls, and destined to become the scene of much innocent fun.

Upstairs, next, into all the cosy bedrooms. With their simple, yet comfortable and artistic furniture, and the brightly polished cots, which to a practised eye betrayed beneath their new coating of red enamel their undoubted identity with some formerly seen in the wards at Guy's. These red cots made a pretty contrast to the walls, softly coloured in green, and showed that someone with an eye to artistic effect had been at work. Then downstairs into the cheery rooms below, with their folding doors wide open to admit the rapidly increasing guests, and where all the available chairs were fast filling up in anticipation of the opening service of dedication. In the back-ground were to be seen rows of pink uniforms, belonging to the laundry workers at the hospital, who of all those present must have had the keenest, because the most personal, interest in the proceedings of the evening.

Guy's nurses and sisters were also well represented, besides numerous friends of the hospital, who all rallied round this new venture in the spirit of loyalty that Guy's knows so well.

The Bishop's address was short and simple. Its straightforward directness, which dealt not with statistics nor printed reports, nor red-tapeism of any kind, but took a wide, human view of the undertaking, and thus led up to the Divine aspect of loving care for others, appealed to all present by its earnestness and truth.

Surely Guy's, in thus enlarging its borders in this direction, is doing a good work, not only in the present but for the future, in thus sheltering and caring for these helpless little ones, who, through no fault of their own, have their lives darkened on the very threshold.

Now, instead of growing up neglected and uncared for, they will have the same chance as children born in happy circumstances, of looking back in the years to come on a peaceful and sheltered home-life, with wholesome surroundings and an atmosphere of kindly practical love and care.

So it is hoped that all friends of Guy's will interest themselves in "The Haven," visit it, and take their friends to see the little ones gathered there, and thus contribute to make it the success that its enthusiastic originators and supporters wish it to become.

From the Gazette's Special Pathologist.

X.Y.Z., HASTINGS.—No tubercle bacilli can be found in the sputum. PATHOLOGIST.

Reviews.

Practical Nursing. By Isla Stewart, Matron of St. Bartholomew's Hospital, and Herbert E. Cuff, M.D., F.R.C.S., Medical Superintendent of the North Eastern Fever Hospital. Vol. i. (Blackwood. Price 3s. 6d.)

Dr. Cuff's little book on Fever Nursing has shown what an excellent and practical teacher he is; and this volume on General Nursing is as practical and clear in detail as its predecessors, with the advantage of being written in collaboration with a lady highly qualified to deal with the subject. The author's preface says, "It seems to us that the descriptions given in books (of the various nursing operations) are, as a rule, too sketchy." If it were possible for a nurse to be trained on book knowledge only, the help she would receive from a careful reading of these very precise instructions would be as near an approach as she could get to bedside teaching.

The chapters include the general routine of work in the ward, and its hygiene, personal care of the sick, observation of the patient, diet in disease, the administration of baths, packs, medicines, etc., the nursing of sick children, disinfection, and surgical nursing.

The succeeding volume is to deal with special branches of nursing, and some special diseases.

Notes on Folkestone. By Arthur E. Larking, M.D., D.P.H. Cambridge. (J. & A. Churchill, pp. 79. 1s. 6d.)

This little book was written to supply what the author considers a long felt want, as within recent years no book on Folkestone from the climatological standpoint has been written.

While keeping within as small a space as possible, Dr. Larking goes into his subject as fully and accurately as possible. The chapters deal in succession with the topography, history and general description of the town, and later on with the soil, sunshine record, water-supply, drainage, etc. The last chapter but one, the most important of all, deals with the cases suitable for treatment at Folkestone.

Altogether, Dr. Larking's book can be well recommended to every practitioner who wishes to know more in detail of the health resorts of his own country.

Natural and Artificial Methods of Ventilation. (London: Robert Boyle & Son, pp. 66. With supplement.)

This is a compilation by Messrs. Robert Boyle & Son, the well-known sanitary engineers, of all the most recent apparatus for efficient mechanical ventilation. It includes extracts from official reports of commissions on ventilation, and in the supplement are numerous illustrations of the various methods of natural and mechanical ventilation, their benefits and defects.

This small book is very thorough, and should be extremely useful to the sanitary expert who is engaged in the actual practical solution of the problems of efficient ventilation.

Climate. A Quarterly Journal of Health and Travel. Edited by C. F. Harford-Battersby, M.A., M.D. No. 1, Vol. 1. 6d.

This journal is intended to be of use both to medical and non-scientific explorers. The articles contained in it include accounts of travel pure and simple, remarks on climates, notices of the progress of tropical medicine, articles on outfit, and other necessary details. Coming at just the right time, when interest in things colonial is very high, and tropical medicine is taking a prominent place in contemporary medical literature, it should be ensured of success. If subsequent issues are equal in interest to the first, *Climate* should have a healthy future.

Surgery : A Treatise for Students and Practitioners. By Thomas Pickering Pick, pp. 1,176. 440 Illustrations. (Longmans, Green & Co.) 25s.

This volume, by a late Vice-President of the College of Surgeons is, as the author states, the substance of the Lectures on Surgery delivered at St. George's Hospital for the last fifteen years. Certainly no one can suggest that the book is in any sense the champion of advanced or immature ideas. It is not written by a young man with a mass of theory and a minimum of experience, but by a surgeon who, by reason of his experience and opportunities is qualified to write, and in our opinion, is one of the men who should write and substantiate the various lines of treatment by recounting their results and the value of their line of treatment.

We must confess, however, to a very deep sense of disappointment in the book.

It attempts far too much. To treat the whole range of General Surgery, even in the most elementary manner, is sufficient to necessitate a big volume of many hundred pages, but to include in your task the operative treatment of those diseases, a chapter on Diseases of the Female Generative Organs, Diseases of the Ear, and an appendix on Amputation, is both unnecessary and a mistake.

Again, many subjects are dealt with in a most ineffectual manner. The whole subject of Injuries and Diseases of the Head is dismissed in some 40 freely illustrated pages : Cerebral Hæmorrhage and Compression in four ; more space is given to describing Kraske's operation than to the description of Intracranial Suppuration. Appendicitis receives the most meagre treatment, and numerous other inequalities of the same nature are observable, showing a want of proportion between the practical value to a student and the apparent importance attached to the subject by the writer.

The illustrations, too, are of the worst. Many have already done duty in other well known text-books; some few photographs are interesting, but the original drawings, those presumably referred to in the preface as "rough sketches" which have received an "artistic finish" are simply amazing.

What humanity has been guilty of lately that it should merit such a travesty of its form as those depicted on pages 108, 230, 371 and 613, we do not know. Many others, again, are quite useless, aiding the reader little or not at all in understanding the author's description.

On the other hand, several chapters are well written, notably that on the Union of Wounds, and on the whole the matter is clearly and concisely put before the student. Its range is wide and teaching safe, if not very heroic.

It will probably compete with Walsham's Surgery as a favourite for men up for the Conjoint, and in some respects is a much better book.

The publishers, Messrs. Longman & Co., have fulfilled their duties well. The book is clearly printed on good paper and the letterpress is very correct.

Claude Bernard. By Sir Michael Foster. (Masters of Medicine Series. T. Fisher Unwin.)

Book-reviewing consists of two parts, reviewing the subject-matter and reviewing the writer's treatment of it. In this case the writer's fluency and clearness of explanation are well known; and his power of gleaning from the work of others and drawing large-minded general conclusions were established by his own text-book and by the fine speech which he recently made to the British Association this summer. He is undoubtedly a master of English prose.

Now, there is not a great deal to be said about the private life of Bernard, and in this book the private life is spoken of in only two or three chapters, which are sandwiched in between the more technical parts, with obvious advantage to their interest. Bernard, in these chapters, reminds one forcibly of Charles Darwin—a scientific investigator who lived in his work and cared for little else, but yet Bernard was more interesting, more lively ; he was a French version of Darwin. We are shown him at twenty-one, fresh from a little town near Lyons, his only education that of the local Jesuit college, his work that of a chemist's assistant, journeying up to Paris with the successful comedy he had written and seen performed, under one arm, and "Arthur de Bretagne," the heavy tragedy with which he hoped to win eternal fame, under the other. A dramatic critic saw the tragedy and advised Bernard to take to medicine for his livelihood, and so Bernard became a student.

We are next given a graphic account of the position of Physiology in 1835; how that Müller and Volkmann in Germany, Charles Bell and Marshall Hall in England, had already started physiology in the right track of experiment, while France was still divided between the bigoted vitalists, who with Bichât held that vital processes and physico-chemical processes were wholly distinct, and the pure empiricists, who without any definite ideas plodded away vainly and at random with their experiments. It was Bernard who came to settle what physiology was. While Ludwig, Helmholtz, Du Bois-Raymond and Brücke worked away in Germany,

Bernard, first as Magendie's prosector, then as his successor in the chair at the college, toiled away at the physico-chemical experiments, and gradually thought out some of the most essential problems in the new science. In this book we have a detailed account of the steps by which, in attempting to solve one problem, he happened upon a trail which eventually led to the epoch-making discovery of glycogen. In the same way the train of thought pursued by Bernard in the great discovery of vaso-motor nerves, is clearly related in the language of his biographer, and carries the reader with it. So many physiological problems were touched upon by Bernard in his life that the book is thus a running comment on the whole science, and should be recommended to all men reading the subject as a side-light upon and a relief from the ordinary text-book.

Bernard's great discoveries dated from 1850 to 1855, when he was under forty years old. After that he adopted more general views in his lectures, his opinion being that every man should be his own philosopher, doing experimental work first and generalizing only afterwards. He would emphasize the importance of the imagination. "Put off your imagination," he said, "as you take off your overcoat when you enter the laboratory, but put it on again, as you do your overcoat, when you leave the laboratory." As Sir Michael happily puts it, he was the "Apostle of Physiological Experiment," and by scrupulous attention to details he fell on great results and achieved greatness. He was a splendid looking man, of fine physique, and such men as Gambetta and Rénan were amongst his close friends. His greatness was recognised, even in his lifetime, and he was for the first time of any man of science, accorded a public funeral at his death, in 1877, at the age of sixty-four.

In his life there are many things to encourage the ordinary medical student of to-day. Bernard was of low origin, he had no opportunities but such as he made for himself; his research could be done only in a laboratory fitted up by himself. At school he was considered lazy and unpromising. He was thwarted in his choice of a profession; he married badly and had a wretched home-life, and on the brink of his great discoveries in 1851 he almost despaired of his future and thought of becoming a surgeon. He was saved by his intense watchfulness and careful thought. Even when led astray, as by his experiments on the Chorda Tympani, his genius led him to consider as a parallel the liver, and on this he became famous. His work was always solid work, checked and promoted by constant and deep thinking. *O si sic omnes!*

Papers by Guy's Men.

Localisation of Bullets by X-rays. By R. Clement Lucas, B.S., F.R.C.S.—*British Medical Journal*, 21st October.

A Case of Secondary Thyroid Growth. By A. W. Sheen, M.S., M.D.—*Ibid.*

The Defence of the Cardiac Orifices other than Valvular. By D. W. Samways, M.A., M.D.—*Ibid*, 28th October.

In Lighter Vein.

The opening meeting of the Debating Society must be described as a success, for there were many speakers. I counted at least three whose remarks had some slight reference to the subject under discussion.

The honourable opener prefaced his speech by saying that he hoped nothing would be done that night which might embarrass the Government. (Loud laughter.) He then traced the history of the Transvaal from the beginning.

The honourable opposer disagreed with the honourable opener. He traced the history of the Transvaal from the middle, and said he feared to say all he had to say lest he should embarrass the Government. (Roars of laughter.)

An honourable member rose and disagreed with both the honourable gentlemen who had already spoken. He said he hoped honourable members opposite would remember that this was a critical time for the Empire, and that nothing should be said to-night which might embarrass the Government. (Laughter, in which the President joined.) He then traced the history of the Transvaal backwards.

An honourable member of the opposition said he had no wish to clog the hands of Her Majesty's Ministers. (Laughter and cheers, in which the speaker himself joined.) He then read several extracts from the various conventions, and said that he didn't see that what applied to one did not apply to the other. And if it did he couldn't see what difference it made.

A gentleman then called the attention of the house to the subject at issue. (Sounds of dissent from both sides of the house.) He made no reference to the history of the Transvaal or the hands of the Government. He sat down amidst pronounced silence.

Another honourable member rose and said he trusted that anything he had to say might not embarrass (the rest of the honourable member's remarks were rendered inaudible by peals of laughter, during which he resumed his seat).

Several other gentlemen spoke with similar success, after which the vote was put. Dr. Pavy

announced that the "Ayes" had it. The "Ayes" seemed very pleased to hear that they had it, and the "Noes" unanimously agreed that the "Ayes" could keep it; so Mr. Cox and Mr. Box were satisfied.

A shilling subscription has been started here for the *Telegraph* "Women and Children's Fund." Patriotism has put Mr. Steele Perkins on his metal.

The poets are busy just now. Mr. Austin has unburdened himself with a quaintly humorous war sonnet, and Mr. Kipling has weighed in with an unworthy jingle. South Africa has been the grave of many reputations, and it hasn't done Mr. Kipling any good.

Meanwhile, where is Mr. Clement Scott? Surely this is the chance of his lifetime. I present this stanza to Mr. Scott as something to work on.

Shall I tell you a tale of the war, lads,
A tale of Britannia's sons?
Right oh! if you'll spare a trifle,
For the women and little ones.
For the girl that he leaves behind him,
The blackguardly Boer to kill;
For the infant who lisps to his daddy,
"Remember Majuba Hill!"

No doubt Mr. Wilson Barrett would recite the poem between the acts of the "Sign of the Cross."

Sport.

Rugby Football.

CARDIFF v. UNITED HOSPITALS.

(From Western Mail.)

Whether it was the defeat at Newport, or that the climatic conditions at the time set for the commencement of the match on the Cardiff Arms Park were by no means bright, one would hardly like to say; still, in contradistinction to previous occasions on which the Hospitals have paid their usual visit, the "gate" was very small, not more than 4,000 spectators being present at the time set for the kick-off. For some time before the play started the Whitchurch Brass Band, under the leadership of Mr. Rowland, gave selections from their repertoire. M'Intyre came into the Cardiff team as A. N. Other, but the visitors turned out as announced. The teams took the field as follows:—

CARDIFF.—Winfield (back); V. Huzzey, W. Jones, Ivor Jones and Ricketts (three-quarter backs); Sweet-Escott and Hughes (half-backs); J. Blake, Phillips, G. Dobson, Wheeler, Hines, W. W. Hughes, Neill and M'Intyre (forwards).

HOSPITALS.—H. Wheelwright (back); L. F. Hanbury, A. O'Brien, F. W. Sime and H. E. Norton (three-quarter backs); F. E. Walker and E. T. Holland (half-backs); R. C. Mullins, D. H. Trail, A. H. Wall, R. C. Lawry, R. J. Thompson, A. C. Hudson, Y. F. Cunningham and G. A. Weir (forwards).

Referee: Mr. J. B. Mathew, Welsh Rugby Union.

The Hospitals started play at 3.40, Sime kicking-off. Huzzey returned, and play settled down just inside the Cardiff half. The first attack came through Ricketts, who, coming down the right wing—he having changed over with Huzzey—was forced into touch just as he looked like getting clear. Then on the other wing Huzzey got a chance, but when he had beaten two or three men he passed back in the centre to Hughes, who failed to take a very easy pass, and so missed a grand opportunity. Play after this came to the centre of the field, where one of the Hospitals' men made his mark, and a place was taken for goal. The ball fell short, however, and Jones returned to touch close on the centre. The next few scrimmages fought out were in favour of the Hospitals, their backs having several chances. O'Brien punted to Winfield, and tried to follow up, but Winfield cleared easily enough, although his kick lacked length. Cardiff had an opportunity on the left wing shortly after this, but again their passing was erratic, and a capital opening was missed. A short rush by the home forwards, headed by Dobson, gained Cardiff a few yards, and then Sime looked dangerous for the Hospitals, only being pulled down by Winfield just on the Cardiff goal-line. Ricketts made a strong run after this that brought play down to the centre. From here, Hughes made a beautiful run for Cardiff, and when he reached the Hospitals' full-back, he passed out to the left wing. His pass was badly mulled, but Hughes recovering the ball very cleverly, and, dodging two or three men, he ran on again, and went over in the extreme corner with a beautiful try, which Winfield failed to convert. From the re-start, Cardiff were soon again attacking, but they finished up by Huzzey trying a shot at goal, which only forced a minor. From the Hospitals' drop-out, Winfield made a nice return to touch at the visiting 25. Here play stuck for a few minutes. Then the Hospitals' forwards, who seemed fresher after a short delay, rushed play up to the Cardiff 25. Here the Cardiff backs started again, but a couple of consecutive attempts at passing by them were slovenly and gained them no ground. A free, took the Hospitals to the Cardiff 25, where they in turn lost a chance by bad passing on their left wing. Then a long kick by Huzzey from the centre of the field, caused the Hospitals to touch down and concede a minor. Winfield made a fine return from the visitors' drop-out, and play settled down at the medicos' 25. Hughes stopped a rush of the Hospital forwards very smartly, but immediately afterwards Hanbury gained the visitors a lot of ground with a useful kick to touch. The following up

of the Cardiff forwards sent play back a few yards, although the Hospitals' scrimmagers soon regained the lost ground. Winfield was just in time to turn the ball to touch at his 25, after a short kick by Hanbury, and then play came more towards the stand side, where three or four of the Cardiff backs muddled matters up between them very badly, and Sime, picking up, dodged across close by the posts with a try, which was converted. This reverse seemed to stir up the Cardiffians a bit, and at the start they made a warm attack. Then, out by the medicos' 25, Cardiff made matters even still hotter, and after one check, Hughes nearly struggled over. Two or three light scrums were fought out right on the line, the Hospitals having a fifth three-quarter out. Cardiff lost a chance by heeling out at this point, and the Hospitals managed to get back to their 25. Here, again, Hughes proved too smart for them. He picked up in the loose, feinted to pass out to the left, and then dodged in to the right, beating two or three men, and getting over by the posts with a try, which Winfield converted. In the few minutes before the interval Cardiff pressed, and a long cross kick by Rickett's forced Cardiff's third minor.

	G.	T.	M.
CARDIFF	1	1	3
UNITED HOSPITALS	1	0	0

Dobson started the second half for Cardiff, and, after a reply by the Hospitals and a follow-up by them, Cardiff were awarded a free alleged off-side tackling. This put Cardiff well inside the home 25. Huzzey made one strong run on the left, and then crossed the ball over to the centre. The Hospitals' custodian missed it as it dapped, and M'Intyre, running by him, dropped on the ball close by the posts and scored a try, which Winfield had no difficulty in converting. The forwards for a time had it to themselves, and the Cardiff scrimmagers, getting slightly the upper hand, worked up to the Hospitals' 25, where a penalty was given against the Cardiffians. Winfield returned it smartly, however, and Hanbury fumbling his pass, a couple of Cardiff forwards pulled him down, and scrimmaging was re-started close to the Hospitals' 25 line. Another free against Cardiff was given at this spot, and, Ivor Jones' kick being charged down, play settled right on the centre line. Here, out of some loose play, Dobson got possession, and, beating half a dozen opponents very smartly, he went right through up to the visiting full back, where he threw over to W. Jones, who ran on, and, getting there just as Sime overhauled him, scored a try, which Winfield converted. Play for the next few minutes was rather brighter, the Cardiff forwards in particular being noticeable for some good work. Ivor Jones got a pass out from the scrimmage shortly after this, and made a very pretty run on the right, and, breaking into the centre scored Cardiff's fifth try, Winfield on this occasion failing to place the goal. Immediately after this Cardiff were again dangerous, Ricketts punting across and putting them all on side. The referee adjudged they were off-side, however, and penalised them. They did not gain much ground from this, but immediately afterwards Hanbury and O'Brien came down the right wing, and were only stopped when close on the Cardiff 25. Then Sime, one of the Hospitals' three-quarters, had to leave the field with his left arm hanging helplessly by his side. Play on resuming was just on the centre line and for a few minutes was fairly even. Hanbury and O'Brien relieved matters by a nice attack down the right wing, whilst the same players were conspicuous a moment later by another very determined attack, which was only stopped close on the Cardiff goal-line. The Cardiff scrimmagers soon relieved matters, and dribbled back to the visiting 25. A lot of loose work between the forwards followed this, and at the finish, matters ended up fairly even on the centre line. It was very scrambly for a few minutes, but then there came a nice bout of passing across to the left wing, and Huzzey getting possession, sprinted right round the medicos' full back and scored right behind the posts. Winfield converted. Time was soon afterwards called.

	G.	T.	M.
CARDIFF	4	2	3
UNITED HOSPITALS	1	0	0

Association Football.

GUY'S v. FELSTED SCHOOL.

This match was played at Felsted on October 21st. Guy's lost the toss. Wiltshire kicked-off with the wind slightly in our favour. It was some time before our men got together, and there was a good deal of loose play in front of the School goal. Soon, however, Barber got the ball, and after some excellent play, scored the first point of the match. Although the game was very even, at times the School pressed us hard. Barber managed to score another goal before half-time.

On changing over, the School immediately began to press, but their shooting in front of goal was decidedly weak. Our forwards, however, twice broke away, and two more goals were scored for us by Barber and Wiltshire. For the rest of the time the School pressed hard, but only scored one goal, and thus the match ended 4–1 in our favour.

In goal, Heap was very safe, and made one or two brilliant "saves." The defence was all that could be desired. Of the forwards, Barber showed a decided knowledge of the game, and was very conspicuous throughout.

GUY'S v. FOREST HILL.

This game, played at Honor Oak Park on Saturday 28th, resulted in a win for the hospital by 5 goals to nil, after a very poor game. In the first half Guy's scored twice through Norton and had nearly all the play, though Forest Hill should have scored from a break away early in the game. In the second half, our men pressed right through but did not add to their score until near the finish owing to general slackness in front of goal. Norton and Wiltshire scored.

The play of most of our men was not up to the usual standard, possibly due to the inability of their opponents to extend them. Of the new men, Chignell at outside left played well, combining nicely with Norton. Edey on the right seldom had the ball sent to him, but made one or two good runs. Bacon, the new half, will evidently be most useful. Heap in goal is very safe, and saved well on several occasions. Team :—

Guy's.—Heap (goal); Robson and Corfe (backs); Bacon, Shepherd and Greenfield (halves); Edey, Manser, Wiltshire, Norton and Chignell (forwards).

GUY'S 2ND XI. v. L. C. C.

This game was played at Honor Oak Park on Saturday, October 21st, in a dense fog. Accurate play was utterly impossible. Guy's ultimately proved the winners by 2 goals to nil. Team :—

Guy's.—Wadson (goal); A. Leeming, J. Braithwaite (backs); S. Bent, D. G. Greenfield, B. Rust (half-backs); H. L. Dent, T. A. Chignell, H. K. Lacey, W. O. Roberts, P. A. Peall (forwards).

GUY'S 2ND XI. v. R. M. A. 2ND XI.

This match was played at Woolwich on Wednesday, October 24th, and after a fast game resulted in a win for Guy's by 9 goals to 3.

At the start both sides had substitutes in goal, and in a few minutes Guy's had scored twice, but before our goal-keeper had arrived, the Academy equalized. During the first half, play was very even and fast, and it was chiefly due to some good play among our forwards that we were leading by 4 goals to 2. On re-starting, the Academy pressed hard for a short time and scored by a good shot from the centre. After this, their defence became weak, and our forwards scored freely, the game terminating as stated. Edey played a really good game on the right wing. Chignell also played well, but was too slow and left his place too much. Carter in goal made some extremely good saves. Team :—

Guy's.—H. H. Carter (goal); J. Braithwaite, A. Leeming (backs); P. V. C. Bent, D. G. Greenfield, N. P. Shepherd (half-backs); T. H. Edey, T. A. Chignell, H. K. Lacey, F. Morres, F. Morris (forwards).

United Hospitals' Hare and Hounds.

After a run over the five mile course on October 21st, the Annual General Meeting of the above club was held, and the following officers elected for this season. Several new men turned out, and among them T. C. Mills ought to prove useful in matches.

President: L. A. Dunn, Esq., M.S. Captain: T. C. Mills (Middlesex). Hon. Treasurer: P. G. Easton (St. Mary's). Hon. Secretary: R. S. Roper (Guy's). Committee: F. Tullock (St. Mary's), A. C. Birt (St. Thomas's), L. S. H. Glanville (Guy's), H. D. Cochrane (St. Thomas's).

Appointments.

CIVIL.

STARLING, PROFESSOR E. H., F.R.S., has been appointed an Examiner in Physiology for the Medical and Surgical Degrees of the Cambridge University.

WEBBER, HENRY WOOLMINGTON, M.D., M.S. Lond., L.R.C.P. Lond., M.R.C.S., has been re-appointed Medical Officer to the Provident Department of the Plymouth Public Dispensary.

NAVAL AND MILITARY.

Surgeon W. J. MAILLARD, V.C., M.D., R.N., is promoted to be Staff-Surgeon.

C. R. EVANS, M.R.C.S., L.R.C.P., has been nominated Surgeon-on-Probation for the Royal Army Medical Corps.

DECORATION.

The Queen has been pleased to grant to HENRY ALFORD MOFFAT, F.R.C.S., Her Majesty's Royal Licence and Authority that he may accept and wear the Insignia of a Chevalier of the Royal Order of the Saviour. The decoration has been conferred by the King of Greece in recognition of services to the Greek wounded during the late war between Greece and Turkey.—*Lancet*, 21st October.

Births.

COCK.—On October 18th, at Porchester Houses, W., the wife of F. William Cock, M.D., of a son.

HARRIS.—On October 19th, at Bell Street, Shaftesbury, the wife of W. J. Harris, M.B., F.R.C.S. Eng., of a son.

MARSHALL.—On October 21st, at Oak House, Huddersfield, the wife of William Laurence Wright Marshall, of a son.

WOHLMANN.—On October 28th, at 9, Gay Street, Bath, the wife of Arthur Stanley Wohlmann, M.D., B.S., of a daughter.

Marriage.

RAMSAY—BARRETT.—On October 18th, at St. John the Baptist, Kensington, by the Rev. W. M. Spencer, Henry Ward Ramsay, son of W. H. Ramsay, R.N., of Mutley, Plymouth, to Hilda, daughter of Alfred E. Barrett, M.R.C.S. Eng., (and grand-daughter of the late Rev. and Hon. Thos. Robert Keppell), of 123, Holland Park Avenue, W., and Grimston, Norfolk.

Deaths.

KELBE.—Died at Alice, Victoria East, Cape Colony, on September 25th, 1899, Elfrida Gertrude, the dearly loved wife of Walter Edward Kelbe, District Surgeon, and daughter of the late P. Bernard, Esq.

ROUTH.—On October 21st, after a short illness, Alfred Curtis Routh, M.R.C.S., of St. Leonards-on-Sea.

ED.—H. L. E.

Contents.

	PAGE
SUMMER DIARRHŒA IN CHILDREN: Clinical Lecture by Dr. Newton Pitt	477–484
HOSPITAL NEWS	484–486
PASSIM	487–489
WITH THE ARMY MEDICAL CORPS IN SOUTH AFRICA: By Our Special Correspondent	489
NURSING NOTES	490
CORRESPONDENCE: The Christmas Tea in Out-Patients; To Cambridge Men; A Correction, and some Knowledge	490–491
IN LIGHTER VEIN	491
NURSING NEWS	492
SPORT: Rugby Football—Guy's v. Old Leysians; Guy's and St. Thomas's v. Penarth; Guy's v. Rosslyn Park; Guy's v. Catford Bridge; Guy's "A" v. St. Thomas's "A"; Guy's "A" v. Beckenham; Guy's "A" v. London Irish "A"; Guy's "A" v. Rosslyn Park "A"; Guy's "A" v Westminster Hospital; Guy's 3rd v. Merchant Taylors' 2nd; Guy's 3rd v. Tonbridge School 2nd; Guy's 3rd v. Blackheath Proprietary School. Association Football—Guy's v. Reigate Priory; Guy's v. St. Leonards; Guy's v. Old Cranleighans; Guy's 2nd v. Eversleigh; Guy's 2nd v. Old Cranleighans' 2nd. "Hos.-Sch." (Guy's Hospital Officers' and Servants' Cricket Club)	492–496

Calendar of Coming Events.

November, 1899.

Sat. 18.—Messrs. Howse and Jacobson's take-in; Drs., S, Clarke and T. H. B. Dobson; Cl., W. B. Secretan.
1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I.—Bedford, away.
II.—Beckenham, away.
III.—Hammersmith "A," home.
IV.—S. Paul's Sch. III, away.
G.H.A.F.C., I.—Ewell, away.
II.—Ewell II, home.

Mon. 20.—Final Fellowship Exam.
Cambridge 1st and 2nd M.B. Schedules to be brought to the Medical School Office for signature.

Tues. 21.—Cambridge 3rd M,B. Schedules to be brought to the Medical School Office for signature.

Wed. 22.—1.15 p.m., Clinical lecture by Mr. Howse.

Thur. 23.—Messrs. Davies-Colley and Symonds' take-in; Drs., E. C. Bevers and E. G. Wales; Cl., L. Wilkin.
5 p.m., G.H.C.U., Missionary Meeting.

Sat. 25.—1 p.m., Clinical lecture by Dr. Perry.
G.H.P.P.S.—"Infusion and Transfusion," by G. S. Simpson.
G.H.R.F.C., I.—Old Merchant Taylors, away.
II.—Old Merchant Taylors, home.
III.—Dulwich College II., away.
IV.—Wimbledon "A," away.
G.H.A.F.C., I.—Weybridge, away.
II.—Central Tech. Coll., home.

Wed. 29.—1 p.m., Clinical lecture by Mr. Howse.
G.H.A.F.C., I.—Royal Vet. Coll., home.

Thur. 30.—Messrs. Lucas and Lane's take-in; Drs., S. Hodgson and J. A. B. Hammond; Cl., E. C. Mullins.
G.H.C.U.—Address by W. Bertham Watson, Esq. (St. Mary's Hospital).

December.

Fri. 1.—January Appointment List opened.
Last day for names to be sent in for 1st, 2nd and 3rd M.B. Camb. Exam.

Sat. 2.—1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I.—Blackheath, away.
II.—Polytechnic, away.
III.—Manor Way "A," home.
IV.—Streatham IV., away.

Guy's Hospital Gazette,

NOVEMBER 18, 1899.

Summer Diarrhœa in Children.

CLINICAL LECTURE BY DR. NEWTON PITT.

October 7th, 1899.

GENTLEMEN,—I propose taking up this lecture, and possibly the next, with the subject of Diarrhœa, but more particularly with the varieties which are so prevalent during the summer, many cases of which have been in the hospital during the past three months.

First of all, I would premise that diarrhœa is a symptom, and not a disease; hence it is very difficult to classify its varieties. The causes are numerous, and several varieties may result from the same cause. The difference in the symptoms is also very great, and, therefore, it is quite impossible to give any very satisfactory classification. A great deal of work has been done during the last ten years in connection with the microscopical changes which take place in the alimentary canal in the various forms of diarrhœa, and an attempt has been made to form a classification based upon these, but clinically, you will find that it is not possible to distinguish and predicate beforehand what changes will be found in the alimentary canal. In acute fatal cases, the patients may die before any obvious changes take place; and in the more chronic cases it is quite impossible to speak with any certainty as to what changes will be found. Much work has also been done with regard to the bacteriology. Several observers in various parts of the world have systematically examined the organisms to be found in the fæces, and also, post-mortem, in the wall of the alimentary canal, in the various forms of diarrhœa; and although much information has been collected, it is not possible to form any classification based upon the varieties of the organisms. Although, as I shall point out, there are a large group of cases, particularly those which come under the term summer diarrhœa, which are undoubtedly due to the active changes resulting from the abnormal growth of organisms, still there are other cases in which they are not the essential cause, but which are due to such conditions as unsatisfactory feeding, and to depressing external conditions, such as exposure.

Typical cases of each variety can be defined, but the various forms run into each other;

there is no hard and fast line between the groups. Very often diarrhœa will commence as a simple non-inflammatory diarrhœa, and then pass into one of the other forms. While a particular case under observation may at first be typical of one group, that will by no means prevent the appearance, within a few days, of symptoms which will transfer it to another. Our classification, therefore, is not scientific, but is simply one of convenience.

Classification of Diarrhœas.—

1. Simple non-inflammatory diarrhœa.
   (Including that due to anæmia, Bright's disease, heart disease, etc.)
2. Mycotic or acute fermentative diarrhœa.
   (Including that due to septicæmia, pneumonia, suppuration, peritonitis, measles, scarlet fever).
3. Cholera infantum, or English cholera.
4. Inflammatory diarrhœa.
   (Including that due to dysentery, cholera, typhoid, pyæmia, tubercle).
5. Chronic diarrhœa.

1. *Simple non-inflammatory Diarrhœa.*—This is a form which is very seldom fatal, and when it is, there are practically no anatomical changes to be found. There is little or no pyrexia and no severe vomiting. This is a very common form of diarrhœa; it is largely due to improper feeding. Babies are more liable to diarrhœa than adults, because their skin is much more sensitive to changes of temperature, and their alimentary canal is more affected by irritants.

Babies may be over-fed, they are often supplied with unsuitable food, and they may be fed too frequently. There is a great tendency to give them too much farinaceous food; and all these errors are common causes of diarrhœa. If the surface of the skin is chilled, whether by a sudden change in the weather, or by any condition that exposes a child, or even an adult, to rapid cooling, the tendency is for diarrhœa to come on. In connection with dentition, there is always more or less disturbance of the digestion, and hence a liability to diarrhœa. In this case the diarrhœa may come on more or less acutely, but will only last two or three days if carefully treated. The motions which normally, as you know, are of the colour and consistency of mustard in infants, tend to change colour, to become greenish, and very often to contain mucus; to diminish in consistency and to increase in frequency. These forms of diarrhœa soon pass off if carefully treated with a laxative—because in almost all you will find in the early motions undigested food—and later with an aromatic and alkaline mixture, and the child is kept on a low diet. The most important rule is to, at once, cut down the amount of proteid material in the milk by diluting it or by substituting whey—in slight cases this is very often sufficient. Sometimes it is desirable for a few hours to stop the milk altogether, and treat it as we should a serious form of diarrhœa. These cases are common, and with care, the majority of them are readily cured.

Besides these causes to which I have referred, diarrhœa may occur in the course of the specific fevers. Very often at the onset of pneumonia, measles or scarlet fever, the most prominent symptom may be diarrhœa, which may for a time obscure the diagnosis. Then again, various other diseases, such as peritonitis, empyema and uræmia may be accompanied by diarrhœa. Some of these cases fall into one class and some into another.

2. *Mycotic or acute fermentative Diarrhœa.*—I want particularly to devote attention to this group of cases, viz., those in which there is evidence of more or less constitutional disturbance. In such, the temperature is always raised, the child shows more or less evidence of severe poisoning, and a toxic condition with great constitutional disturbance. In some the mischief seems to affect chiefly the lower portion of the alimentary canal, and there is no vomiting; in others the vomiting is a marked symptom, but there is no need to separate the two groups of cases. The acuteness of the symptoms varies very much, they are often the sequel of diarrhœa which has been allowed to run on unchecked for days; in such cases the child gradually becomes worse, the temperature runs up, and the character of the motions changes; or an attack may begin quite acutely without any previous chronic diarrhœa.

Symptoms.—The motions are invariably more or less offensive, sometimes extremely so, or they have a very acid odour. The change in the odour of the motions, and the fact that they are very often frothy, justifies you in concluding that fermentative changes have been going on in the alimentary canal. At first, the motions often contain undigested food, but as soon as the contents of the alimentary canal have been cleared out, you generally have fœtid, foul, more or less slimy motions, greenish in colour, and varying according to the acuteness of the disease; in some cases they are very watery, in some they consist almost entirely of mucus, and in many they contain more or less blood. The

child rapidly loses weight, but with careful treatment, in the majority of cases, improves within a few days, and although it is for sometime liable to relapses, most cases recover. But unless carefully looked after, the attacks are apt to recur, or to take the form of inflammatory diarrhœa, in which there are more severe symptoms and more marked anatomical changes. Some drift into a chronic diarrhœa which runs on for months, and the child may be carried off by an intercurrent disease, such as pneumonia or a specific fever.

3. *English Cholera.*—This is a rare disease. The important points in the diagnosis are: the illness is very acute, there is extreme prostration, and, after the alimentary canal has been emptied, the fæces consist of rice-water stools with scarcely any odour; the child quickly becomes collapsed and soon has a pinched appearance; the vomiting is extremely frequent. The disease may prove fatal within twenty-four or forty-eight hours; the patient passes into a state of stupor or coma, and perhaps has convulsions before death. Although many severe cases of acute dyspeptic diarrhœa are called English cholera, it is better to keep the term for this rare and too often fatal form.

4. *Inflammatory Diarrhœa.*—The inflammatory diarrhœas include cases in which the symptoms at first very much resemble those of the second group—at first you cannot distinguish the one from the other—but instead of clearing up in two or three days, the temperature remains raised, the symptoms are more severe, and they vary according to the portion of the alimentary canal that is affected. When the stomach as well as the ileum is involved the vomiting is severe. When the lower part of the colon is involved there is tenesmus, a large amount of mucus is passed, and there are frequent attempts to make the bowels act. When the inflammation is limited to the ileum and the upper portion of the colon, you do not notice the mucus in the motion, but you can always find it on microscopical examination. I will refer directly to the anatomical changes.

5. *Chronic Diarrhœa.*—This includes those cases which persist; either from neglected treatment or from anatomical changes, such as ulceration, atrophic changes, or from specific lesions such as those of typhoid, tubercle, dysentery, lardaceous disease, etc.

Anatomical Changes Correspond to each of these Several Groups. The group of Simple Diarrhœa is one in which there is more or less irritation from various causes, but in which no anatomical change takes place in the bowel itself.

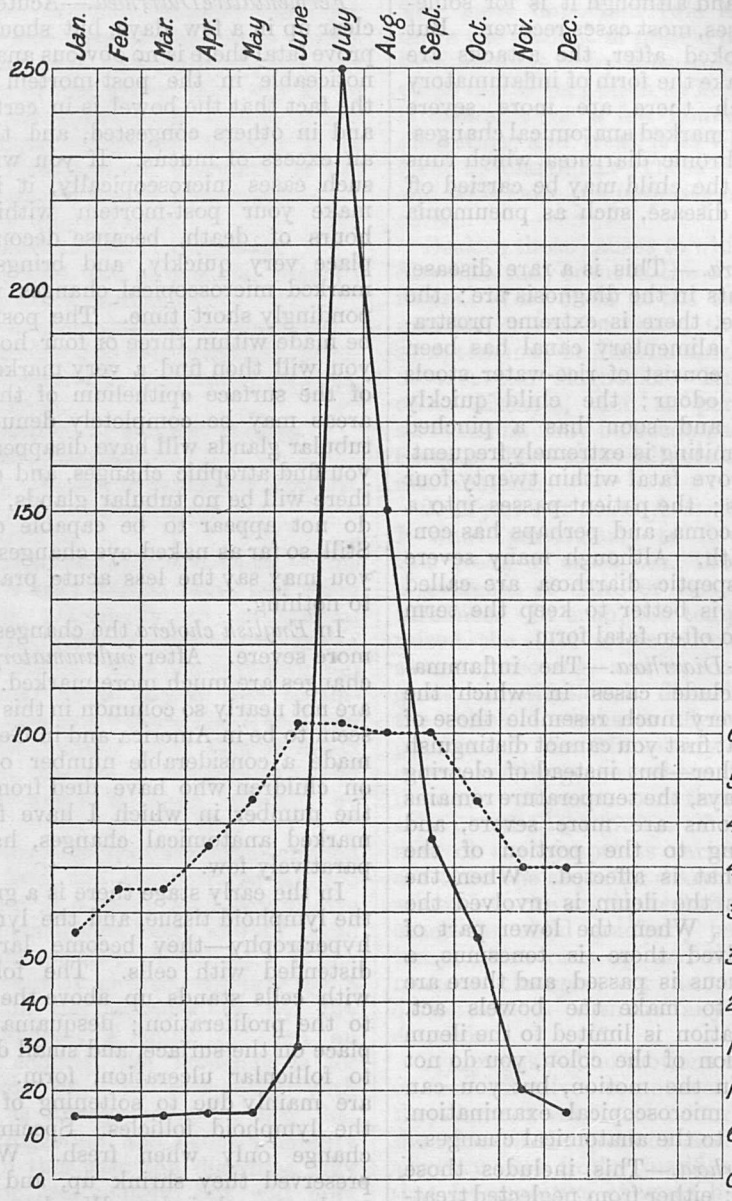
Fermentative Diarrhœa.—Acute cases generally clear up in a few days, but should they quickly prove fatal there is no obvious anatomical change noticeable in the post-mortem room, beyond the fact that the bowel is in certain parts pale, and in others congested, and that it contains an excess of mucus. If you wish to examine such cases microscopically, it is necessary to make your post-mortem within a very few hours of death, because decomposition takes place very quickly, and brings with it very marked microscopical changes within a correspondingly short time. The post-mortem must be made within three or four hours after death, you will then find a very marked proliferation of the surface epithelium of the bowel; large areas may be completely denuded, and many tubular glands will have disappeared. In cases you find atrophic changes, and over large areas there will be no tubular glands, as these glands do not appear to be capable of regeneration. Still, so far as naked-eye changes are concerned, you may say the less acute practically amount to nothing.

In *English cholera* the changes are similar but more severe. After *inflammatory diarrhœas* the changes are much more marked. These lesions are not nearly so common in this country as they seem to be in America and in Germany. I have made a considerable number of post-mortems on children who have died from diarrhœa, but the number in which I have found any very marked anatomical changes, have been comparatively few.

In the early stage there is a great increase in the lymphoid tissue, and the lymphoid follicles hypertrophy—they become larger and more distended with cells. The follicle crammed with cells stands up above the surface, owing to the proliferation; desquamation then takes place on the surface, and small depressions, due to follicular ulceration, form. These ulcers are mainly due to softening of the surface of the lymphoid follicles. Specimens show this change only when fresh. When they are preserved they shrink up, and the change is no longer obvious. We have no specimen in our museum showing this condition, but it is not very infrequent in the post-mortem room to see numerous follicular ulcers, sometimes in the colon, but more commonly in the ileum.

Sometimes there is also a diffuse cell-infiltration due to inflammatory changes. The cell-infiltration will affect, first of all, the

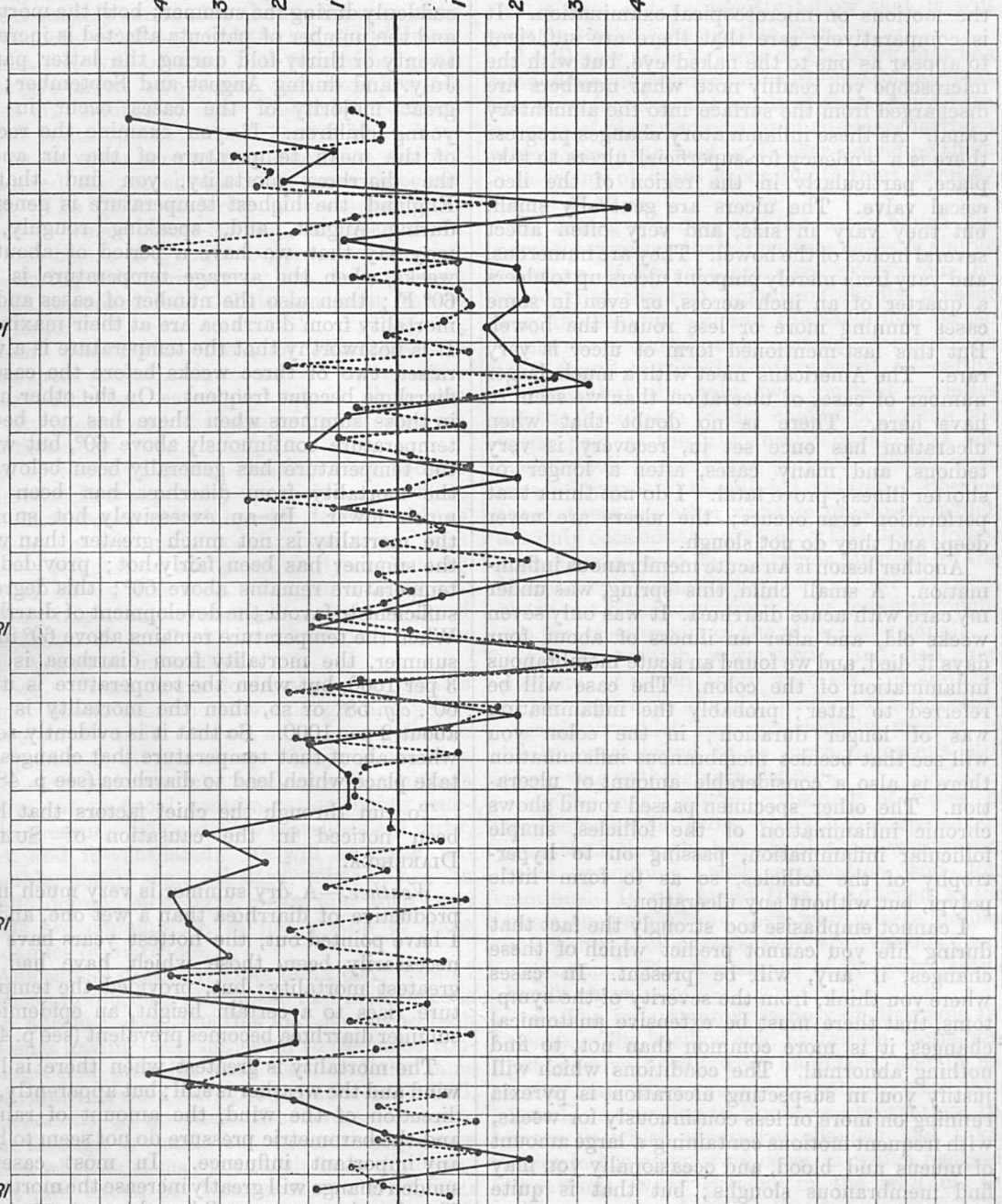
A Chart showing the Diarrhœa Mortality in London in an Average Year, 1891.



The black line indicates, as shown by the figures on the left, the number of recorded deaths from diarrhœa each week (taking a mean for each month); the dotted line shows the mean monthly temperature of the air.

The mortality remains fairly uniform, about fifteen weekly, until May; it rises slightly in June, but towards the end of July it rapidly rises to two hundred and fifty each week, an amount seventeen times as great as that in the early part of the year. It falls to one hundred and fifty weekly in August, and to seventy-five in September; it then gradually decreases, but is not low until November. The increase takes place very suddenly, and only lasts for a very limited period. It will be noted that it is preceded by a rise of the temperature of the air to above 60°. In the present year, 1899, during the maximum period of the weekly mortality the number of deaths has been exceptionally high, reaching four hundred and seventy for the last week in July and for the first two weeks in August.

A Chart to show the Diarrhœa Mortality in London, per million, between the years 1861 and 1897 (after Parkes).



The black line corresponds to the diarrhœa death-rate, per million, for each year, as shown by the figures on the left. The dotted line indicates the mean temperature of the air for the second and third quarters of each year; the number of degrees above or below the mean is shown by the figures on the right.

mucosa, and in the more severe chronic forms of diarrhœa the muscular coat also. In these cases numerous leucocytes can be found in the motions on microscopical examination. It is comparatively rare that there are sufficient to appear as pus to the naked eye, but with the microscope you readily note what numbers are discharged from the surface into the alimentary canal. As these inflammatory changes progress there is a tendency for superficial ulcers to take place, particularly in the region of the ileo-cæcal valve. The ulcers are generally small, but they vary in size, and very often affect several inches of the bowel. They are numerous, and vary from merely pinpoint ulcers up to ulcers a quarter of an inch across, or even in some cases running more or less round the bowel. But this last-mentioned form of ulcer is very rare. The Americans meet with a much larger number of cases of ulceration than we seem to have here. There is no doubt that when ulceration has once set in, recovery is very tedious, and many cases, after a longer or shorter illness, prove fatal. I do not think that perforation ever occurs; the ulcers are never deep, and they do not slough.

Another lesion is an acute membranous inflammation. A small child, this spring, was under my care with acute diarrhœa. It was only seven weeks old, and after an illness of about four days it died, and we found an acute membranous inflammation of the colon. The case will be referred to later; probably the inflammation was of longer duration; in the colon you will see that besides membranous inflammation there is also a considerable amount of ulceration. The other specimen passed round shows chronic inflammation of the follicles, simple follicular inflammation, passing on to hypertrophy of the follicles, so as to form little polypi, but without any ulceration.

I cannot emphasise too strongly the fact that during life you cannot predict which of these changes, if any, will be present. In cases where you think, from the severity of the symptoms, that there must be extensive anatomical changes, it is more common than not, to find nothing abnormal. The conditions which will justify you in suspecting ulceration, is pyrexia running on more or less continuously for weeks, with frequent motions containing a large amount of mucus and blood, and occasionally you may find membranous sloughs; but that is quite exceptional.

To discuss more fully the group of cases which I have called fermentative diarrhœa. If you examine the records of the front surgery, or the Registrar General's returns, whether in England, America, or on the continent, you will notice that the mortality from diarrhœa runs up very suddenly during the summer; both the mortality and the number of patients affected is increased twenty or thirty-fold during the latter part of July, and during August and September; the great majority of the cases occur in very young children. If you examine the records of the mean temperature of the air and of the diarrhœa mortality, you find that in England the highest temperature is generally during August, and, speaking roughly, we may say that we have a period of about six weeks, when the average temperature is over 60° F.; then also the number of cases and the mortality from diarrhœa are at their maximum. It is noteworthy that the temperature is always raised two or three weeks before the cases of diarrhœa become frequent. On the other hand, in those summers when there has not been a temperature continuously above 60°, but where the temperature has generally been below 60°, the mortality from diarrhœa has been very much lower. In an excessively hot summer the mortality is not much greater than when the summer has been fairly hot; provided the temperature remains above 60°; this degree is sufficient to favour the development of diarrhœa. When the temperature remains above 60° in the summer, the mortality from diarrhœa is over 3 per 1000, but when the temperature is under 60°, *e.g.* 58° or so, then the mortality is only about 2 per 1000. So that it is evidently somewhere about that temperature that changes can take place which lead to diarrhœa (see p. 480).

To run through the chief factors that have been noticed in the causation of Summer Diarrhœa.

Weather.—A dry summer is very much more productive of diarrhœa than a wet one, and, as I have pointed out, the hottest years have not necessarily been those which have had the greatest mortality; but, provided the temperature rises to a certain height, an epidemic of summer diarrhœa becomes prevalent (see p. 481).

The mortality is greatest when there is least wind and the weather is still; but apparently, the direction of the wind, the amount of rainfall and the barometric pressure do not seem to have any important influence. In most cases a sudden change will greatly increase the mortality. This has been very striking this summer. On one or two occasions when a sudden change took place in the temperature, the number of cases of diarrhœa began at once to increase.

Age distribution.—The disease affects people of all ages, but it is very much more prevalent amongst children, and the great mortality is almost entirely confined to them. On examining the records of cases admitted to a Children's hospital, it will be seen that four-fifths of all cases are under two years, but very few are under six months of age. The most common period is during the second year of life. Very few cases occur in children that are entirely breast-fed, the percentage being under three per cent. The great majority of cases occur in children when breast-feeding has been given up, and before they have begun cooked food—and during this period they are fed on more or less uncooked food. This is a most important factor.

Local conditions.—Cases of diarrhœa are much more prevalent in towns and amongst the poorer children, especially where they are densely packed and the sanitary conditions are unsatisfactory.

As to the type of the children that become affected. It is especially the sickly ones, those who have recently had specific fevers, such as measles or whooping cough; and those with chronic indigestion are particularly liable to be carried off by diarrhœa. Therefore, it is extremely important to treat even slight forms of indigestion in small children, and not to allow them to run on unchecked.

Food.—There is no doubt that diarrhœa is largely due to decomposition changes and pollution of cow's milk. Cow's milk, as supplied to the public, is almost always dirty; it contains more or less fæces; the bacillus coli, which is equivalent to fæcal contamination, being generally present. The ordinary cowsheds are dirty, dark and ill-ventilated. It will be quite impossible, until some change takes place in public opinion, and light, clean, and tiled cowsheds are compulsory, to put a stop to these epidemics of diarrhœa.

Are these cases of Diarrhœa contagious? A case often occurs in a house in which there is also another case, but this may be due to both patients having been subjected to the same conditions, and probably they have had the same food, and therefore have become affected. Still, occasionally in hospitals the disease seems to run through a ward, but again the question arises whether it may not result from the food.

Is the cause of Fermentative Diarrhœa indigestible food? Children eat quite as much indigestible food in winter as in summer, and it is therefore quite clear that although indigestible food may start some changes in the alimentary canal, yet that is not the essential factor; it is simply a predisposing one. In the same way a chilling of the skin will bring on simple diarrhœa, but it does not necessarily follow that it will pass on to the fermentative form.

I will now refer to some of the work that has been done in connection with *organisms* that are to be found in the stools of these cases. In a series of ninety-two cases of summer diarrhœa which were examined by Booker—dividing them into groups of cases according to their severity—first of all,—

a. Taking a group of mild cases which apparently were not toxic, but were cases of simple diarrhœa, of which there were twenty-four, he found that the two organisms chiefly present were the bacillus coli and the bacterium lactis. There are a considerable number of organisms to be found in the alimentary canal of healthy children, but the only two constant varieties are the bacterium lactis, chiefly pervading the upper part of the alimentary canal, and the bacillus coli in the lower portion. These were invariably present in milk-fed children. Besides these, there are other variable organisms which are only occasionally present. But it was found that when a child has diarrhœa, instead of the bacillus coli being limited to the lower portion, there was a tendency for it to be found throughout the greater part of the alimentary canal.

b. Cases which were toxic, and had foul motions, of which there were six; in addition to the organisms already mentioned, some other organisms which are occasionally present in health were found to be more numerous, still there was nothing very definite.

c. The next group consisted of cases of fermentative diarrhœa which had more severe symptoms than the last; in all there were severe toxic symptoms, with emaciation and foul motions. It was found that in addition to the two named organisms, there were a large number of organisms of putrefaction, viz., various forms of proteus. The abundance of the putrefactive bacilli varied.

d. The inflammatory variety of diarrhœa (27 cases). The bacillus coli, bacterium lactis, and putrefactive bacilli were abundant, and in not quite half the cases streptococci were also found. According to Booker's observation, the cases in which ulcerative changes had taken place in the colon were cases in which pyogenic organisms were present in the wall of the alimentary canal, and in these cases pneumonia had not infrequently developed.

Others have carried out observations on similar lines, and have found that pyogenic organisms

are not necessarily present in all cases of inflammatory diarrhœa, but that they occur in the most severe cases where there is ulceration. It is quite clear, therefore, that there is no special organism which is the cause of these fermentative diarrhœas, and on this I want particularly to lay stress. Whilst there is evidence that certain organisms increase in number and in virulence during an attack of diarrhœa, still you cannot say that there is any particular organism which is responsible for the symptoms.

Dr. Vaughan examined cultivations of several organisms which had been separated from the stools of patients with fermentative diarrhœa. He took the fluids produced by the growth in broth of three of the organisms, and injected them into animals, and thereby in each case produced very severe diarrhœa and vomiting, clearly showing that these organisms are capable of producing toxic material, which, circulating in an animal, produce diarrhœa and vomiting. The evidence goes to show that diarrhœa and vomiting in the attacks result from the poisons manufactured by the organisms, but there are probably several capable of producing these results.

Is Summer Diarrhœa due to Putrefactive Changes in the Food before it is taken? Or is it due to changes in the condition of the alimentary canal which allow organisms that are always present to become much more virulent and flourish? At present there is a great divergence of opinion on these two questions.

I would like to draw your attention to one question in connection with the motions, which is an interesting point clinically. Nothnagel examined the fæces of a large number of cases of inflammatory diarrhœa, with a view particularly of determining whether you could say from the nature of the fæces which portion of the alimentary canal was involved, and he came to certain conclusions which are interesting. First of all, when the changes were in the colon, he found that there was much more mucus than when only the upper portion of the bowel was involved; and that when mucus was not obviously present in the motion the colon was certainly not involved. When the rectum was involved there was tenesmus; when the sigmoid, you generally found scybalous masses in the motions, and when the upper portion of the colon, the mucus was mixed with the fæces. The higher the mischief the more thorough the admixture of the mucus and the fæces. On examining these motions for bile pigment with nitric acid he obtained no bile pigment reaction. The following are his conclusions: the presence of mucus unstained by bile pigment pointed to involvement of the colon; the more thorough the admixture of the mucus and the fæces, the higher in the colon was the seat of the catarrh; the more abundant the mucus, the lower the affected area.

Where the catarrhal changes are limited to the duodenum and ileum, there is no mucus visible to the naked eye, but if you take a small portion of the fæces and examine it between two glasses under a microscope, mucus is distinctly visible; it is bile-stained, and on testing with nitric acid will give Gmelin's reaction; the probability being that in these cases the increased peristalsis passes on the contents of the bowel so quickly that the changes which normally take place in the bile as it passes down the bowel cannot take place. It is still an open question as to what is the process by which the bile, which is diffusible, is changed into the stercobilin, which is non-diffusible, and whether the whole change is due to the bacillus coli. If you take some bile and put it in a vessel with a piece of small intestine, shake them up together and allow them to stand, no urobilin is formed. If, however, you take a piece of large intestine and some bile, shake them up and stand, then urobilin is formed. So that there is something about the large intestine which is capable of so altering bile, that it no longer gives a bile pigment reaction. In those cases in which the catarrh is limited to the upper portion of the bowel and in which the colon is not involved, you have a microscopical amount of mucus in fæces which give a bile pigment action.

Hospital News.

CLASSIFIED LIST OF CASES.

In the Medical Wards.

Cases under Dr. Taylor.

Mary	38.	Chlorosis.
	39.	Gastric ulcer. Perforation. Operation 17 hours after.
	40.	Graves' disease.
	42.	Chronic tubal nephritis.
	43.	Typhoid. ? Relapse.
	45.	Chorea.
	46.	Acute rheumatism.
	48.	Gastric ulcer.
Cot	57.	Broncho-pneumonia.

PHILIP	21.	Appendicitis.
	26.	Tertiary syphilis. Lardaceous disease.
	28.	? Adherent pericardium.
	29.	Bulbar paralysis.
	30.	Colitis. ? Chronic intussusception.
	33.	? Actinomycosis.
	34.	Peripheral neuritis.
	36.	Mitral stenosis. ? Ulcerative endocarditis.
	38.	Tuberculosis.
	40.	Acute colitis.

CASES UNDER DR. BRYANT.

MARY	25.	Chorea.
	27.	Mitral stenosis and regurgitation. Tricuspid regurgitation.
	27.	Carcinoma lung.
	28.	Bronchitis.
	29.	Enteric.
	30.	? Cirrhosis liver. ? Ascites malignant.
	32.	Gastric ulcer.
	34.	Empyema. Operation.
	35.	Aortic aneurysm.
	37.	Enteric.
STEPHEN	21.	Empyema.
	23.	Streptococcal empyema.
	24.	Diabetes.
	25.	Enteric. Relapse.
	26.	Enteric.
	27.	Mitral and tricuspid stenosis and regurgitation.
	28.	Right pleuritic effusion.
	29.	Pericarditis with effusion. Mitral regurgitation.
	30.	Mitral and aortic stenosis and regurgitation.
	31.	Appendicitis. Operation.
	32.	Left hemiplegia following injury to head.
	34.	Enteric.
	35.	Aphasia.
	36.	Double pneumonia.
	37.	Right pleurisy with effusion. Paracentesis.
	39.	Aortic disease. Hypertrophy and dilated heart.

CASES UNDER DR. HALE WHITE.

MARY	13.	Mitral stenosis and regurgitation.
	14.	Typhoid.
	15.	Acute rheumatism.
	16.	Mitral stenosis and regurgitation.
	19.	Adiposis dolorosa.
	20.	Gastric ulcer.
	21.	Typhoid.
	22.	Mitral stenosis and regurgitation.
	23.	Nephrorraphy.
	24.	Gastric ulcer.
PHILIP	1.	Double lobar pneumonia. Antipneumococcin used. Relapse.
	2.	Aortic and mitral regurgitation. Healed phthisis.
	3.	Aortic stenosis. Mitral and tricuspid regurgitation.
	4.	Carcinoma of stomach.
	6.	Mitral disease.
	7.	Diabetes mellitus.
	8.	Typhoid.
	9.	Plumbism.
	10.	Cerebral tumour. Operation.
	11.	Enterica.
	12.	Chronic Bright.
	14.	Syphilitic myelitis.
	15.	Chorea.
	17.	Mitral regurgitation.
	19.	Phthisis.
	20.	Acute rheumatism. Mitral disease.

CASES UNDER DR. PERRY.

MARY	1.	Chronic peritonitis. Perihepatitis.
	2.	Gastric ulcer.
	3.	Typhoid.
	5.	Typhoid.
	6.	Typhoid.
	7.	Malignant growth of transverse colon.
	8.	Gastric ulcer.
	9.	Enlarged liver. Gall stones.
	10.	Eczema.
	11.	Rheumatic fever.
	12.	Rheumatic fever.
Cot	51.	Marasmus.
Cot	57.	Atelectasis pulmonaria.
STEPHEN	1.	Eczema.
	2.	Rheumatic fever.
	3.	Fibroid lung.
	4.	Broncho-pneumonia.
	5.	Chronic interstitial nephritis.
	6.	Pneumonia.
	7.	Hemiplegia.
	8.	Mitral aortic tricuspid regurgitation. Aortic and mitral stenosis. Pleuritic effusion. Aspiration.
	9.	Functional nervous disorder.
	10.	Typhoid.
	12.	Bronchitis and asthma.
	13.	Empyema.
	14.	Enteric fever.
	16.	Cirrhosis of liver.
	17.	Enteric fever.
	18.	Traumatic neuritis.
	19.	Typhoid.
	20.	Cystitis.

In the Surgical Wards.

Cases under Mr. Howse.

Naaman	2.	Epithelioma of floor of mouth.
	5.	Inguinal hernia. Radical cure.
	9.	Varicose veins. Congenital cyst of neck.
	13.	Urethral stricture. Cystitis.
	18.	Talipes equino-varus. Removal of astragalus.
Dorcas	7.	Burns. Thiersch's skin grafting.
	17.	Bilateral tubercular disease of hip.
	18.	Syphilitic stricture of rectum.
Astley Cooper	6.	Fractured humerus. Ruptured urethra.
	27.	Compound fracture of jaw and crushed foot.

Cases under Mr. Davies-Colley.

Job	1.	Inguinal hernia. Radical cure.
	2.	Trigeminal neuralgia. Injection with osmic acid.
	3.	Tubercular arthritis of hip.
	6.	Epithelioma of tongue. Excised.
	7.	Chronic vaginal hydrocele. Incised and drained,
	10.	Fistula in ano.
	20.	Inguinal hernia.
	25.	Strangulated inguinal hernia. Kelotomy
Lydia	3.	Myeloid sarcoma of head of tibia.
	5.	Necrosis of femur.
	8.	Rachitis. Bowed tibiæ and femora.
	11.	Fractured patella.
	13.	Nasal obstruction. Polypi.
	18.	Tubercular axilliary glands.
	Cot A	Cleft palate. Uranoplasty.
	Cot C	Macrostoma. Accessory auricles.
Cornelius	8.	Scalp wound. Fractured ribs.
	13.	Scalp wound.
	17.	Compound fracture of tibia and fibula.

Cases under Mr. Lucas.

Martha	4.	Fractured ribs. Pleurisy.
	7.	Synovitis of knee. Gonorrhœal.
	9.	Tubercular glands in axilla.
	21.	Fractured lower end of radius and ulna, lower end of humerus and backward dislocation of radius and ulna.
Lazarus	3.	Chronic synovitis of both knees.
	5.	Epithelioma of tongue. Excision.
	6.	Epithelioma of tongue. Excision.
	9.	Undescended testis.
	10.	Recurrent sarcoma of scapula.
	16.	Tuberculous testis, knee, and psoas abscess.
	20.	Displaced semilunar cartilage.
Astley Cooper	7.	Lacerated jaw and cheek.
	10.	Pott's fracture.
	23.	Fractured femur.

Cases under Mr. Golding-Bird.

Luke	7.	? Renal calculus. ? Tubercle.
	8.	Multiple gummata.
	10.	Appendicitis.
	13.	Urethral stricture. Rapid dilatation.
	14.	Ununited tibia.
	16.	Sarcoma of jaw.
	17.	Exostosis of tibia.
Charity	2.	Strangulated femoral hernia. Kelotomy.
	7.	Fractured surgical neck of humerus. Wired.
	9.	Growth of sigmoid. Colotomy.
	14.	Acute epiphysitis of hip.
	16.	Tubercular knee. Erasion.
	17.	Empyema.
Cornelius	2.	Fractured patella.
	5.	Scald.
	6.	Fractured base of skull. Crushed arm. Amputation.
	8.	Bullet wound in chest.
	16.	Ruptured eye-ball. Excision.
Astley Cooper	4.	Fractured olecranon.
	5.	Hæmorrhage into spinal membranes.
	9.	Fractured base of skull.
	Cot.	Comminuted fracture of humerus. Fractured ribs.

Cases under Mr. Jacobson.

Naaman	21.	Inguinal hernia.
Dorcas	20.	Papilloma and epithelioma of tongue. Excision.
	21.	Enlargement of thyroid. Partial thyrodectomy.
Patience	16.	Varicose veins.

Cases under Mr. Symonds.

Job	13.	Vesical calculus. Enlarged prostate Suprapubic lithotomy.
	16.	Tubercular elbow. Excision.
Martha	19.	Old injury to mandible. Ankylosis Excision of condyles.
	20.	Thyroid enlargement. Thyroidectomy Partial
	22.	Empyæma of frontal sinus.

Cases under Mr. Lane.

Lazarus	11.	Chronic intestinal obstruction. Operation. Adhesions round splenic flexure of colon.
Martha	11.	Movable kidney. Nephrorraphy.
	12.	Tubercular arthritis. Dislocation of hip.
Patience	17.	Chronic ulcer of leg. ? Tertiary syphilis.

Cases under Mr. Dunn.

Luke	3.	Thyroid cyst.
	4.	Appendicitis.
Charity	20.	Umbilical hernia.
	Cot D.	Bilateral tuberculous synovitis of knees.
Patience	15.	? Sacro iliac disease.
Samaritan	9.	Gangrenous stomatitis.

Passim.

THE last fortnight at the hospital has been particularly uneventful; it is a true saying that "happy is the nation that has no history," and by analogy we ought to congratulate ourselves upon some few halcyon days in this weary world. On the other hand, such absolute peace is most ominous for the scribes who work to fill out each number of the GAZETTE, for though clinical matter may be in abundance, this same clinical matter, to judge from personal observation, is exactly the portion of the GAZETTE which the average man at the hospital does not read. He takes his GAZETTE, opens it to see if there are any pictures, looks over "Passim" and "In Lighter Vein," possibly grunts at the one and occasionally laughs at the other, shuts the GAZETTE up, and says, "A dull number," every time. And dull we are most often and dull we shall remain till most of us realize that, barring personalities, which, though amusing, cannot, in good taste, be published, there is very little humour in the hospital. And all this is by way of preamble to the fact that there is practically nothing to record this fortnight, and to warn people that dull times make a dull GAZETTE.

THE new scheme for the reconstitution of the GAZETTE committee and its working has now been sanctioned by the Treasurer and signed by the contracting parties—the present GAZETTE committee, the Physical Society and the Clubs' Union. It is not necessary or desirable to print all the details of the new arrangement, but the following details may be of interest, as the composition of the old GAZETTE committee was apparently a source of great wonder to many.

THE GAZETTE Committee shall consist of three Members of the Hospital or School Staff, to be appointed yearly by a School Meeting; two Students appointed yearly by the Clubs' Union Council; the President of the Residents for the time being; an Editor appointed by the Committee; a Manager appointed by the Committee, and other Students not less than four in number and not more than six co-opted by the Committee. It will be seen from the above statement that an attempt has been made to make the Committee as representative as possible, and in future there will be no difficulty in finding out who is on the GAZETTE Committee and how he got there.

THE new arrangement is a great advance upon the old scheme in many ways, and it will be a better committee. The old committee and GAZETTE arrangements dated back to before the formation of the Clubs' Union, when the Physical Society was the only recognised body in the hospital among the students. But the growth of the Clubs' Union and consequent increase in the circulation of the GAZETTE necessitated some re-arrangement of affairs, and thanks to Drs. Perry and Shaw as advisers, the present scheme has been evolved. It now only remains for a committee under the new régime to be formed and the matter is at an end.

As a general thing it is a very wise rule in this place that no answer is made to the occasional allegations against the hospital in the daily press. As long as one knows at the hospital that the state of affairs as reported was not in the least like the state of affairs as it really was, and that the hospital had only acted in strict accordance with regulations, no good can be done by entering into recriminations with the newspapers. Rather one remains quiet with a good conscience in the knowledge that those who have any expert acquaintance with the medical profession will realize the absurdity of the remarks.

BUT last week there occurred in the columns of the *Daily Mail*, among other papers, a very inaccurate account of a local inquest, with a paragraph in another part of the paper with equally inaccurate deductions. To explain their errors is not necessary here, and would be of no avail, as what mischief there was to be made has been done. All we would urge upon the staff of the *Daily Mail* is this, that with their enormous daily circulation and their growing influence they should have a higher sense of their responsibility, both to the public and the institution they attack, than to accept without verification the account of an ordinary coroner's court reporter, and comment upon it as if it represented fact. A paper which is striving towards better things might do themselves more justice if they took the trouble to ascertain the facts before they published a complaint or insinuation, such as that of last week, against a pure charity, which gives very material help, and help in the matter of life and death, to upwards of 70,000 people annually.

WE publish in another column a letter from Mr. F. E. Fremantle, who has recently gone

out with the forces to South Africa as a Civil Medical Officer attached to the R.A.M.C. From latest news he is probably now either at Cape Town at the base hospitals or he has gone on with the Roslin Castle to Durban. In any case we hope to have a further account of military surgical work from his pen at an early date.

We have news also of another Guy's man with the forces at the Cape. Surgeon C. M. Beadnell, R.N., of H.M.S. Powerful, has landed with one of the naval brigades in Cape Colony, and when last heard of he was at De Aar.

It was an unfortunate thing that of all days in the year the electric light should have failed throughout the hospital on the occasion of the visit of men from all other hospitals for the Clinicals in the M.B. It is disconcerting, to say the least of it, to have to write an abstract of clinical cases in the short period allotted, but to grind it out in Stygian darkness dimly illuminated by discrete candles must be trying to the most hardened. Probably the liberal supply of examination tea and cake hardly sufficed to dispel the gloom which this melancholy occurrence cast over all the candidates.

The full effect of the five years' curriculum is beginning to be felt at all the London hospitals. Not only are the yearly entries all round smaller than they were five years ago, but the number of qualified men available for locums and appointments is pitiably scarce compared to former days. In the summer vacations experienced locums can command almost any price they like, and even in a season like the present there are practically no men available if someone is urgently needed at short notice.

As long as there are residents in the hospital, and as long as children *will* get diphtheria, there will, every three months or so, be disputes as to who ought to do the tracheotomies. He would be a bold man who unofficially would lay down the law upon this matter, for passion rises very high upon points of etiquette. Men have even been known to lose their tempers in these discussions. Of course, if men were not human, and always saw two sides to a case, and never wanted what was not theirs by rights, there would be no trouble, but the millenium is not here yet. Wherefore, let us have an official ruling applying to all occasions and all conditions of residents, and in the future, *peace!*

The Annual Meeting of the Officers and Servants' Cricket Club was held on October 31st, 1899. The report was read to the meeting and showed a most satisfactory state of affairs. The club has been trying its strength against stronger opponents this year but yet has held its own: if the work of the past is any guarantee of the future, next season's work should be eminently satisfactory. The following officers were elected: President, H. C. O. Bonsor, Esq.; Vice-Presidents, Dr. Perry and Dr. Shaw; Captain, E. Arnold; Vice-Captain, E. J. Lyons; Treasurer, S. H. Croucher; Hon. Secretary, E. A. Pelling; Committee, E. G. Copsey, W. C. Hancock, and A. W. Pelling.

On Wednesday last the Rev. F. H. Rice, Assistant Acting Chaplain, left the hospital to be married, and we wish him the best of good fortune. Mr. Rice had been at the hospital just twelve months, and was very keen on the place, and worked his hardest, and will be very much missed, especially by the men among the patients. His place is filled temporarily by the Rev. W. M. Bottome.

The match against Catford Bridge last Saturday attracted a fair crowd to Honor Oak Park, and it is a pity the weather turned out so unpropitious. What with wind and showers, matters were bad enough for the players, and must have been decidedly worse for the spectators. Some good bouts of passing marked the first spell, but the ball soon became too greasy, and the kick-and-rush game was the only possible one. The hospital forwards showed much better staying powers than their opponents, and their loose rushes were occasionally very good. Thomas shone, especially in the second spell, the game suiting his skirmishing style of play. Louisson passed well at half-back, and with added weight and experience should be useful in the position. Weight is, indeed, badly wanted behind our scrum, and our three-quarters, clever enough in the attack, will require all their gameness when on the defensive. We cannot but think that O'Brien is neglecting his feet, his kicking being far behind his last year's work, as was shown by his failure to drop a goal which he attempted from a free-kick, when it seemed as if a placed ball would have been more effective.

Owing chiefly to damages sustained in Wales we could only muster a weak team in the match against Rosslyn Park. Our defeat was,

therefore, not unexpected, but there was no excuse for the big score our opponents put up. Our attack had no sting in it, and the defence was weak all round, some of the backs being very feeble in their attempts to hold the ball. We hope to see this result reversed when we meet the Park for the return match.

THE appeal made by Mr. F. E. Walker, in another column for donations and help towards the Out-patients' Christmas Tea is very timely. Though Christmas is still some way off, it is necessary to commence the very extensive preparations beforehand. Contributions came in so very readily last year that it augurs well for this year's undertaking. Above all we would impress upon all men who are at present working in Out-patients that it is almost incumbent upon them to lend a helping hand, both on the day of the Tea itself and in the work of decorating such an enormous department beforehand.

With the Army Medical Corps in South Africa.

(BY OUR SPECIAL CORRESPONDENT.)

Las Palmas, Canaries,
Wednesday, October 25th, 1899.

Just a line to report progress. We, the Roslin Castle, are coaling; and a miserable mess and commotion it makes. Most of us—officers and N.C.O.'s—accordingly are ashore, and before we leave this evening fully expect one of the other troopers to come up with us.

We started gaily on Friday from Southampton, the Yorkshire (Bibby line) and Manila (P. & O.) heading the way, while the Lismore Castle and Harlech Castle (like ourselves of the Castle line) were to follow us. Although no one was admitted to the docks, there was a huge crowd to see us off, including Lord Wolseley and his staff, who inspected us first. As each vessel started, all the men on board and the crowd on shore sang "Rule Britannia" and "God save the Queen," and shouted themselves hoarse; and it was a fine sight to see the great ships, swarming with khaki and scarlet, swing past us behind a tug and down the Southampton Water. We caught up the Manila at dinner-time and the Yorkshire next morning; and so, at present, we lead the way.

There are 1,086 men and 70 officers on board, consisting of General Hildyard with his Staff of the 2nd Brigade (1st Division), the 2nd Battalion of the West Yorkshire Regiment, with Col. Kitchener in command, one bearer company of the R.A.M.C., various "details" of the A.S.C. and A.P.D. (weird-looking mortals), and nine of us civil surgeons. Your correspondent's colleagues are a distinguished lot; if they have not been H.-S.'s or H.-P.'s, and been on plague duty in India as well, they have at least served in the Cuban war or spent two years with Colonel Martyr in Uganda. One is suspected of being also a journalist, as he spends his days in writing; but the correspondent of the GUY'S GAZETTE has hitherto escaped suspicion.

Most of the day is spent in the physical enjoyment of excellent food, all kinds of tobacco and very healthy *sleep; but in the intervals one reads novels and occa*sionally military surgery; and they do talk of physical drill, revolver practice and variety entertainments.

It has been good sport on shore in this strange, out-of-the-way little island. It belongs, like the rest of the Canaries, to Spain, and its ways, its people and its arrangements are Spanish in the extreme. Every other shop is a cigar-shop, but it is hardly necessary to add that every tenth house is an English place of business, and even the cigar-shops exhibit as their most prominent ware the well-known blue tins of 3-Castles' Cigarettes. H.M.S. Niobe, with her four funnels, is the most prominent feature in the seascape, and half the ships in the harbour, and all the decent ones, are English. The inhabitants must have profited enormously by to-day's business seeing that the General was the only man on board to speak Spanish, and the common mode of doing business has been to hold out a handful of coppers and let the wily Spaniard take what he considered advisable.

Altogether, Her Majesty's troops are enjoying themselves pretty well and keeping quite fit. We are taking on board as much coal as we can hold, for use on the Natal Railways, as they telegraph that the Dundee mines have stopped work; and as soon as that dirty process is over we shall go on our way rejoicing.

F. E. F.

Pass List.

Examination for the Membership of the Royal College of Physicians, October, 1899.

D. W. Samways, M.A., M.D. Camb., L.R.C.P.

Final Conjoint Examination, October, 1899.

MEDICINE AND SURGERY.—*G. M. Brown, *A.H. Palmer.

MEDICINE AND MIDWIFERY.—*J. F. Northcott.

SURGERY AND MIDWIFERY.—*P. C. P. Ingram.

MEDICINE ONLY.—H. B. Dismorr, B. W. Moss, *E. R. Row, *W. G. Stewart, J. B. A. Treusch, *D. P. Watson, *L. Wilkin.

SURGERY ONLY.—J. B. C. Brockwell, *T. W. S. Browne, E. Cohen, H. B. Foster, E. W. Goble, J. E. Harper, *W. W. Harrison, *R. Michell, *E. E. Parrett, *J. L. Payne, W. M. Thomas.

MIDWIFERY ONLY.—J. Atkins, R. M. Barron, T. H. Body, E. H. Felton, R. W. B. Hall, *H. Leader, C. A. Lower, O. Marriott, *D. J. Munro, *A. W. Penrose, C. B. Sells, G. Shorland.

*Denotes completion of examination.

Nursing Notes.

THE Nursery and Clinical are apparently making preparations for a state of war. Outside the barriers, earthworks to a considerable extent are being thrown up, whilst inside, should the enemy advance so far, mines are being laid to foil them. Two murderous engines which remind one of nothing so much as a species of Jabberwock chewing rock and stone, which spit forth fragments into your eyes, are placed in masterly position covering the road to the nursery and the entrance to the laundry; arrangements that appear like shells are piled about. The most peaceful looking articles are four baths sitting in Clinical front garden; are these to form ambuscades or are we going to start a public wash-house? Does all this mean war? Or is it only the plumber.

This leads me to speak of the burning question of the hour, "To bathe or not to bathe, whether 'tis nobler"——well, we won't go into details, the point is, the nursery and medical dormitory nurses have been offered the choice of a cold bath or none at all lately (lately comprises some months off and on). Personally we prefer none at all, but fear of public opinion induces us to suffer shiveringly. We aren't sure to whom to address our complaints, but of one thing only are we certain, that pipes, bag-pipes and water-pipes, are all man's province (or should be). The nursery is afflicted—but I have said so much about the hot water that I will leave the electric light grievance to another day.

That fell, if undignified disease, measles, has been busy in our midst lately. Two of the fairest and best of our flock have been seized, whilst the College, purely out of sympathy, has contributed three of its members. The sufferers have retired to a health resort somewhere within the four mile radius.

We hear no mention of the Pro's. entertainment; surely it is being kept very quiet. The two previous years many meetings had been already held, whilst all we know of it now is a big query mark. It makes us think of that beautiful little poem, "Where are the pros. of yester-year." Or did someone whisper, "tableaux."

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

The Christmas Tea in Out-Patients.

DEAR SIR,—May I ask you of your good nature to allow me space to call the attention of all and sundry to the fact that the Third Annual Tea for poor children of the Borough, will be held on Christmas afternoon in the Out-patient department. And, Sir, I do this early for the reason that if the work is not undertaken early our efforts run the risk of being swallowed up in the vortex of the Christmas preparations which are such a popular and commendable feature of our hospital life. The old proverb says that a shoemaker should not go beyond his last, and men are inclined to ask why they are invited to undertake a job which is perhaps somewhat alien to our work here. But, Sir, I am sure a little thought will convince them more than any words of mine, that this out-patient tea, given as it is only to the poorest children of the neighbourhood, must indeed benefit not only the children themselves but our hospital too, by showing the parents that we take more than a technical interest in their welfare and inducing them to regard with more friendly eyes the institution which does so much for them. It was the wish, Sir, of the founder of this tea, that everyone connected with the hospital should have the opportunity of helping, and your far-reading journal is obviously the most suitable medium for inviting their aid. Some seventy or eighty pounds are necessary to carry out the original idea of a good tea with entertainment and presents to all the children, and besides this much practical help at the time is necessary. May I therefore appeal most earnestly to your readers to come forward and help the committee in this useful and, as I have found it, interesting work. I shall be most pleased to receive the names of any who would be willing to devote their Christmas afternoon to amusing some five hundred of the poorest children of the poor. Gifts, too, of garments, useful rather than ornamental, will be most gladly received by Sister Lily and Nurse Ransford, who have kindly undertaken this department for me, and I need hardly say that any assistance in the way of "the needful" will be most thankfully received by me or any of the committee.

I must apologise, Sir, for the length of this epistle, but can only plead that the object of my appeal is most deserving of your readers' consideration.—And remain, yours, etc.,

F. E. WALKER.

To Cambridge Men.

DEAR SIR,—A club has been formed of the old students of Mr. Beckton, the well-known Preliminary Medical Coach. Its object is to give his former pupils an opportunity of meeting at least once a year at the Annual Dinner (which it is proposed to hold in London), and

thereby maintain or renew friendships first begun whilst working with him. Already the scheme has been enthusiastically received and promises to be well supported. Being largely an Inter-Hospital Club, we trust that you will, through the medium of your columns, give it publicity, and thereby bring it under the notice of those past or present students of Mr. Beckton, who are or have been students of your hospital. To these, full particulars will be given and a hearty welcome accorded by, Yours truly,

H. J. GAUVAIN, Hon. Sec.

St. John's College, Cambridge, Nov. 4th, 1899.

A Correction, and some Knowledge.

DEAR MR. EDITOR,—I see in last week's GAZETTE that the human remains dug up by the workmen during excavating a subway are supposed to be former dissecting room subjects. Allow me to point out that that could hardly be the case as the remains were quite intact, which dissecting-room subjects would hardly be; another point is that the teeth are the teeth of young subjects mostly, and most of them very perfect sets, which the dissecting subject very rarely has. Then, too, the finding of articles with the remains points to their being probably buried at some time when there was fear of infection. I think it most probable that it is a former "plague pit". The finding of a Charles I. penny points to the fact that they were buried about that time. Can anyone suggest the reason of there being so many old tobacco pipes of curious shape in the soil about the remains? It is rather curious, but these pipes still retain a distinct smell of tobacco. I thought you might like to know the facts of the case.—Yours truly,

STUDENT.

Guy's Hospital, November 13th, 1899.

In Lighter Vein.

I have recently been improving the shining odd twenty minutes by reading some American Medical Periodicals. There is a raciness about many of their articles which is entirely foreign to British medical literature, and it has occurred to me that our own *Lancet* and *B. M. J.* might render themselves more acceptable to the general public and even to the medical profession, by adopting something of the manner of their American contemporaries. Even the editors of the annual Guy's Reports might do well to consider this point, for I feel sure, that with care they could bring their annual volume into such demand as to justify them publishing it biennially. Because I love my hospital and my profession I will give a sample, carriage paid, and free of all expense to the purchaser. Thus:—

"THE COCCUS COPPED"

(A case that corpsed me),

By

DR. FREDK. BERE BLACK & DR. CUTE'UN BITT.

Thursday, saw patient. Fat man, with ginger whiskers. Booze written all over his dial. Breath like a sewage farm. Said his occupation was cracking nuts for the blind monkeys at the Zoo. Family history—rotten. Father was a scene-shifter. Mother was a beer-shifter. Had five brothers—all died of the same old complaint. One sister in a lunatic asylum—the only respectable member of the family. Said he had never had a day's illness in his life except small-pox, measles, rheumatic gout and pediculi. History was that on Tuesday last he felt all over alike; on Wednesday he felt all over different. On Thursday he came into the hospital because he happened to be passing.

He was admitted into an empty bed, the full beds being occupied.

On examination the chest seemed to move rather more than at others, and the breath came in and out as though it wasn't satisfied with the accommodation. The chest was resonant all over except for an area of dulness which we disregarded. The pulse was going like a Brighton train in a snow-storm. We auscultated the lungs with one of More, Fun & Johnson's patent Stethostophones and heard a sort of Promenade Concert, which did us in to rights. We then noticed that the patient was drumming "The Soldiers of the Queen" on his abdomen with his fingers. We said to ourselves "What oh!" Then we detected a spot on the Darby, which faded if you pressed hard enough and with one voice we sang—

We will both go to Jericho
If this is not Enteric Oh!

The treatment was obvious. Ten grains of Crotocol (Gallon & Banbury), and twenty minims of Wotjercol (Cheerohs & Welcome) three times a day in the middle of meals. This treatment worked wonders, and would no doubt have done more. Unfortunately, on Sunday the patient hopped the twig. (What oh! the orphans). At the autopsy there was a chunk of lung almost solid enough for building with and the intestine was blank to the world. Evidently the typhoid bug had come down at the first fence and the Fränkel's filly had won in a canter.

A.

Chapel News.

Sunday, November 26th, has been fixed for the Annual Sermons and offertories on behalf of the St. Andrew's Waterside Mission. The preacher at the evening service on that day will be the Rev. Canon Scarth, who for many years has been closely identified with the Mission. The offerings, both on the Sunday and on St. Andrew's day, will be given to the Mission. The contributions from the Hospital amounted last year to £31 15s. 3d. Information about the mission will gladly be given by Sister Ruth.

Nursing News.

MATRON'S OFFICE.

It is with much pleasure we have to record the return of Miss Laurence (Sister Charity). It is now nearly five months since she has been well enough to work consecutively in the ward. We trust that her health is now fully restored.

Miss Clark, who has completed one year's training as Lady Pupil, has been appointed Sister-in-Charge of the Cottage Hospital, Clacton-on-Sea.

From the Gazette's Special Pathologist.

W. S. F., RICKMANSWORTH.—This specimen, on standing, separates into three layers. A shallow upper layer that consists entirely of fat globules. Beneath this, and equal in bulk to three parts of the whole liquid, is urine. Finally, a deposit which consists very largely of fat globules, with some pink urates and large squamous epithelial cells, with a few leucocytes. There is no pus, nor could we detect anything like fæcal contamination. The urine remains quite sweet after some days. It is, therefore, a condition of lipuria, if it is quite certain that the fat is actually passed from the urinary tract. The urine contains, however, a considerable amount of albumen. It seems advisable to retain the name "chyluria" for those cases in which the condition is caused by filaria. As there appears not to be any likelihood that filaria are the causal agent, the exact reason for the state of the urine remains unexplained, so far as a laboratory examination throws any light on it. We recommend re-examination of a specimen not obscured by the presence of fat. Under the circumstances, the case is one of exceptional interest.

C. P., BARTON-UNDER-NEEDWOOD.—No tubercle bacilli could be found in the sputum.

A. J. W., BATH.—This specimen has the usual structure of a corn, the papillæ being much flattened by the pressure of the thickened epidermis. There is no sign of malignant growth.

J. A. H., WALWORTH.—This specimen has the structure of a fibrous epulis, and is not malignant. In the centre it is ulcerated, and the vessels beneath are numerous and dilated.

PATHOLOGIST.

Sport.

Rugby Football.

GUY'S v. OLD LEYSIANS.

(GUY'S, 19 POINTS; OLD LEYSIANS, NIL).

At Wembley Park on Saturday, October 21st, Guy's met and defeated the Old Leysians by 19 points to nil. Thick fog overhung the metropolis during the whole of the day, but at Wembley it had lifted slightly, so play was just possible. Mullins again distinguished himself by losing the toss, and Guy's kicked off, both sides being at the time one short. For some time play ruled even, but on Thomas's arrival, Guy's began to press. A scrum on the Leysian twenty-five line was responsible for an injury to Clark, their half, and he had to be assisted from the field. Very soon after, Watson-Smythe got in rather wide out on the right, and O'Brien converted with a fine kick. Guy's continued to press, but half-time arrived with no further addition to the score.

On re-starting, Sime quickly got over in the extreme left, and followed this up by scoring again ten minutes afterwards. The rest of the game calls for no special description, as the Hospital forwards had all the best of matters, and made the game very one-sided. Mullins and Walker scored further tries. One of these was converted, and Guy's won easily by 2 goals and 3 tries to nil. Team:—

GUY'S.—E. N. Jupp (back); F. W. Sime, A. O'Brien, C. D. Pye-Smith, E. Morgan (three-quarter backs); F. D. S. Jackson, C. F. Watson-Smythe (half-backs); R. C. Mullins, T. P. Thomas, R. C. Lawry, A. H. Wall, D. H. Trail, E. B. Milsom, A. R. Thompson, F. E. Walker (forwards). Referee: E. V. Gardiner.

GUY'S & ST. THOMAS'S v. PENARTH.

(PENARTH, 14 POINTS; GUY'S AND ST. THOMAS'S, 4 POINTS).

This match was played at Penarth on Monday, 30th October, before a fairly numerous, and a certainly enthusiastic attendance. Mullins lost the toss and kicked off against the wind and sun. From the start the game was of a most scrambling character, an evenly contested scrimmage being apparently considered obsolete, while to effect a fair tackle, it was necessary to reduce one's opponent to a state of unconsciousness. The Hospitals were far from being at home at the game, and about ten minutes after the kick-off, the Penarth left wing made a dashing run along the touch-line, which he crossed about six yards from the goal-line; a try was, however, awarded, but no goal resulted. The Hospitals now lost the services of Morgan, and Shorland had to relinquish his work in the pack owing to a damaged shoulder, but he proved very useful as a roving back. The combined team was still somewhat demoralised, and the Penarth backs, who were playing strongly, succeeded in scoring 3 tries, one of which was converted.

After the interval the medicals played with more dash, though hampered by the absence of Morgan, and by the number of crippled men on their side; once or twice they narrowly missed scoring, but the home defence was good, and a fine goal kicked from a mark by Thompson was all that they could obtain, the game ending Penarth, 1 goal 3 tries (14 points), Guy's and St. Thomas's 1 goal (4 points). Team:—

HOSPITALS.—F. E. Walker (back); E. Morgan, A. O'Brien, T. P. Thomas and L. F. Hanbury (three-quarter backs); F. D. S. Jackson and E. Holland (half-backs); R. C. Mullins, D. H. Trail, A. H. Wall, G. Shorland, E. H. B. Milsom, A. J. Thompson, Y. F. Cunningham and G. A. Weir (forwards).

GUY'S v. ROSSLYN PARK.

(ROSSLYN PARK, 19 POINTS; GUY'S, 3 POINTS).

Owing to the absence of Sime, Trail, Jackson, Cutler and Trubshaw, we were greatly handicapped in this match on November 4th, at Richmond.

Guy's lost the toss and kicked off against a strong wind. For a long spell the ball was in mid-field, but at length from a line-out, one of the opposing forwards scored a try. We had only ourselves to blame for this catastrophe, as he should certainly have been collared. Shortly afterwards, from a free kick, Rosslyn Park scored a goal. This was the extent of the scoring during the first half.

With the wind at our backs we hoped to wipe off the deficit, but no sooner had the ball been in play, than a good forward rush took the ball over our goal-line, and one of their men fell on it. A tricky run by Cobb registered a further try, and two more combined rushes again helped to swell the score against us. Two kicks were successful. Just at the close, a good rush on our part ended in Thomas scoring wide out, but O'Brien failed to convert. We were thus beaten by 19 points to 3.

The forwards were too light to hold their opponents, and although they screwed well at times, did not keep the ball at their feet. Both halves were weak in getting the ball away, and we have certainly seen the three-quarter line stronger. Some of the tries against us were due to rushes which ought certainly to have been stopped by falling on the ball. Jupp was not in form, and we should like to see him cooler than he has been. The collaring of all was very high and feeble. A little practice and keenness would do a deal of good to several members of the team, and in this respect the other fifteens can show a decided lead.

GUY'S v. CATFORD BRIDGE.

(GUY'S, 8 POINTS; CATFORD BRIDGE, NIL).

Mullins, for a wonder, divined the turn of the coin, and Catford kicked off against a strong wind. For some time play was of a scrambling character, the forwards on both sides being slow in settling to their work. Our three-quarters took advantage of the wind by getting in some useful kicks, and, following up a high kick of O'Brien's, Milsom tackled the opposing full-back smartly, and Guy's pressed hard for a few minutes before Louisson passed out well from the scrum and got his three-quarters in motion; after a pretty piece of combination among the latter, O'Brien, receiving a beautiful pass from Morgan, scored a try rather wide; he took the kick himself, but failed. The wind continued to increase, and rain now came on; the game rarely being out of the visitors' twenty-five. Jackson nearly scored, but passed rather wildly to a Catford Bridge man, who relieved the pressure by finding touch. Guy's, however, continued to attack, and after a second piece of good work by halves and three-quarters, Morgan ran in, O'Brien being, this time, successful with the kick at goal. Thomas dribbled over soon after, but the visitors were able to touch down, the first spell ending in favour of the Hospital, who held a lead of 8 points to nil.

On resuming, Catford Bridge played with renewed vigour, and for a time looked dangerous, Jupp being on one occasion compelled to touch down. Our forwards were now playing in much better form, some of the wheels and loose rushes being excellent. Thomas in particular was prominent with his foot-work, and was well supported by Manson and Trubshaw, while Mullins and Trail saved well on several occasions. The visitors continued to press at intervals, but had less of the game than we had when assisted by the wind; and towards the finish their lines were menaced more than once by our forwards. The defence on both sides was, however, good, and the game ended with the score unaltered. Guy's, 1 goal, 1 try; Catford Bridge, nil. Team:—

GUY'S.—E. N. Jupp (back); E. Morgan, A. O'Brien, C. D. Pye-Smith, J. T. Hicks (three-quarter backs); F. D. S. Jackson, M. Louisson (half-backs); R. C. Mullins, D. H. Trail, T. P. Thomas, P. Manson, K. V. Trubshaw, A. H. Wall, R. C. Lawry, E. H. B. Milsom (forwards).

Referee: J. Pickett, Esq.

GUY'S "A" v. ST. THOMAS'S "A"

(GUY'S, 21 POINTS; ST. THOMAS'S, 3 POINTS).

Played at Chiswick on October 25th, and resulted in a win for Guy's by 4 goals, 1 try to 1 try. Guy's were a forward short throughout, Nunn failing to turn up. Tries by Malim, Hicks, Collins, Allen and Louisson. Goals kicked by Louisson and Milsom. The forwards greatly improved on their previous displays this season. The halves played well, Wyatt making several openings. The three-quarters proved better when attacking than when on the defence. Harrison's tackling was very poor. Team:—

GUY'S.—E. S. Harrison (back); A. Tollhurst, R. W. Allen, H. N. Grose, J. J. Hicks (three-quarter backs); H. D. Wyatt, M. G. Louisson (half-backs); H. B. Milsom, A. R. Thomson, R. G. Anderson, C. J. Malim, A. W. Gater, L. Moiser, M. A. Collins (forwards).

GUY'S "A" v. BECKENHAM.

(GUY'S, 9 POINTS; BECKENHAM, 3 POINTS).

Played at Beckenham on October 29th, and won by Guy's by 2 goals (1 penalty) to 1 try.

The goals were the result of two very good kicks by Watson-Smyth, try by Moiser. Guy's were again unfortunate in playing short, French being injured after the game had been in progress five minutes. The passing was not good. Wyatt should not stand so close to his partner when waiting for the ball from him. The tackling was of a distinctly "high" order. Team:—

Guy's.—E. N. Jupp (back); Tollhurst, Pye-Smith, Grose, Louisson (three-quarter backs); Wyatt, Louisson (half-backs); Moiser, Thomson, French, Watson-Smyth, Anderson, Nunn, M. A. Collins, Malim (forwards).

GUY'S "A" v. LONDON IRISH "A."

(Guy's, 10 points; London Irish, nil).

Played in pouring rain at Herne Hill, and resulted in a win for Guy's by 2 goals (tries by Allen and Kynaston; goals by Watson-Smythe). The game was chiefly confined to the forwards, who by this time should have learnt to pack better, and the back row should try and keep the ball there, and not keep on kicking it forward into the other pack. Team:—

Guy's.—E. M. Harrison (back); R. Wallen, C. A. E. Ring, H. N. Grose, H. S. Brown (three-quarter backs); E. S. Brown, A. E. Kynaston (half-backs); E. J. Malim, D. P. Watson, A. R. Thompson, R. G. Anderson, C. A. Watson-Smythe, G. Nunn, A. W. Gater, M. A. Collins (forwards).

GUY'S "A" v. ROSSLYN PARK "A."

(Rosslyn Park, 10 points; Guy's, 9 points).

Played at Honor Oak Park, and resulted in a win for Rosslyn Park by 2 goals (10 points) to 3 tries (9 points). Tries were gained by Allen in the first half, and Brown (2) in the second half. Brown played well at half. Of the three-quarter backs, Allen and Tolhurst never made any attempt to tackle. Malim was the best of the forwards. Watson-Smythe wants to put a little more shove in when in the scrum. Rosslyn Park were too short all through. Team:—

Guy's.—E. M. Harrison (back); C. A. E. Ring, R. Willan, R. W. Allen, A. Tolhurst (three-quarter backs); E. S. Brown, A. E. Kynaston (half-backs); E. J. Malim, R. G. Anderson, C. H. Watson-Smythe, G. Nunn, H. W. Gater, F. Featherstone, B. Moiser, M. A. Collins (forwards).

GUY'S "A" v. WESTMINSTER HOSPITAL.

Guy's, 5 points; Westminster Hospital, 5 points.

Played at Honor Oak Park on Wednesday, November 15th, and resulted in a draw, each side scoring a goal. The result fairly indicated the nature of the game, which consisted in the main of alternate forward rushes on each side. In these, Malim, Nunn and Collins were usually conspicuous, Nunn, in particular, put in some effective foot-work. Harrison at full-back played very well, saving his side on numerous occasions. Hicks scored for Guy's, picking up in our opponents' twenty-five.

Brown and Kynaston at half-back played a good saving game, they should send the ball out to the three-quarter line more smartly. Team:—

Guy's.—E. M. Harrison (back); C. Ring, H. N. Grose, —. Brown, J. T. Hicks (three-quarter backs); S. C. Brown, A. E. Kynaston (half-backs); D. P. Watson, E. J. Malim, R. G. Anderson, G. Nunn, —. Beaumont, C. F. Watson-Smythe (forwards).

GUY'S 3rd XV. v. MERCHANT TAYLORS' 2nd XV.

(Guy's, 45 points; Merchant Taylors', nil).

This match was played on Wednesday, November 1st. The Hospital team was too strong for the School, tries being freely scored throughout the game which ended in a victory for the Hospital by 3 goals, 10 tries (45 points) to nil. Harrison converted. Tries were scored by C. Brown (3), Featherstone (4), Reinhold (3), Nunn (2), Watson-Smythe (2), Beattie (1). Team:—

Guy's.—R. D. Bridger (back); E. M. Harrison, G. H. Sherris, C. H. Reinhold (three-quarter backs); A. E. Kynaston, S. C. Brown (half-backs); G. T. Collins, R. G. Anderson, J. Nunn, E. J. Malim, A. C. Watson-Smythe, F. Beattie, J. Featherstone, L. Doudney (forwards).

GUY'S 3rd XV. v. TONBRIDGE SCHOOL 2nd.

(Tonbridge School, 8 points; Guy's, nil).

Played at Tonbridge. Score: Guys, 0; Tonbridge, 1 goal 3 tries. Gardener made a good attempt at a place-goal from a free kick at half-way line, but owing to wind the ball fell short. Team:—

Guy's.—R. D. Bridger (back); H. Palmer, J. J. Gardner, C. H. Reinhold, —. Greene (three-quarter backs); L. Doudney, —. Wallace (half-backs); G. T. Collins, H. Watts, F. Beattie, H. Teall, —. Steele, —. Perkins, —. Marshall, H. D. Smart, B. Moiser (forwards).

GUY'S 3rd XV. v. BLACKHEATH PROPRIETARY SCHOOL.

(Guy's, 13 points; Blackheath School, nil).

Played at Blackheath, on Saturday, November 11th. A very poor game, which ended in favour of Guy's by 2 goals 3 tries to nil. The forwards would persist in keeping the ball instead of heeling, which was very disappointing, though they wheeled in very good style, taking the ball with them. Team:—

Guy's.—R. D. Bridger (back); H. Palmer, R. Willan, C. H. Reinhold, —. Tolhurst (three-quarter backs); L. Doudney, E. Mann (half-backs); G. T. Collins, H. Watts, F. Beattie, L. Moiser, —. Dickson, H. Teall, —. Steele-Perkins, B. Moiser (forwards).

Association Football.

GUY'S v. REIGATE PRIORY.

(Guy's, 3 goals; Reigate Priory, 3 goals).

Played on Saturday, November 4th, in very bad weather. Guy's played downhill during the first half, and though two of our regular halves, Bacon and German, were away, we pressed from the beginning. After ten minutes' play, the forwards made a splendid

rush, and Barber scored the first goal of the game. Reigate then forced the play into our half, and before half-time equalised the score. After changing over, we again pressed hard, and Barber, by a brilliant single effort, scored another goal for us. The forwards were working hard all the time, and after some good play, Norton scored our third point. It looked as if Guy's were going to have an easy victory, and the play was still chiefly in the Reigate half. A quarter of an hour before time our opponents again began to press, and gave Heap in goal, one or two hot shots which he saved admirably. A long shot was headed out by Robson, but Corfe accidently kicked through our goal. Another goal was scored against us just before time was called, and so the game ended in a draw of 3 goals each.

Heap, in goal was safe, and was not responsible for the goals scored against us. The defence was good considering two men were away, and Shepherd played his best game this season, Both Manser and Greenfield worked hard. Barber played an excellent game, and is one of the most useful forwards the team has had for some time. Wiltshire worked like a horse, but had bad luck in his shooting. Edey is inclined to get off-side too often, and Chignell needs more dash, otherwise both are very promising. Team :—

GUY'S.—E. Heap (goal); W. M. Robson, E. Corfe (backs); D. G. Greenfield, N. P. Shepherd, F. B. Manser (half-backs); T. Edey, H. Barber, H. P. Wiltshire, E. L. Norton, T. A. Chignell (forwards).

GUY'S v. ST. LEONARDS.

(ST. LEONARDS, 2 GOALS; GUY'S, 1 GOAL).

Played at St. Leonards on Wednesday, Nov. 8th, in a strong wind, and after much rain. The ground was covered for the most part with mud, and in places there were pools of water. Guy's won the toss, and selected to play against the wind for the first half of the game. At the start we were heavily pressed, but after a quarter of an hour's play the game became more even. Our forwards were working well, and with a fine rush reached the opponents' goal, where Barber put in a splendid shot and scored the first point. The game after this was a trifle ragged, but fairly even, but within ten minutes of our scoring, the opposing forwards made a dash and scored by their inside right. Our back division was called upon to work hard, but though pressed several times, managed to keep the goal safe till within five minutes of half-time. Their forwards then brought the ball down the middle of the field, and passed to the outside left, who appeared to be yards offside. A claim was made, but disallowed by the referee, and St. Leonards scored a second point, the score at half-time being 2 to 1 in favour of St. Leonards.

After changing over, with the wind at our backs, the game changed very materially, but though Guy's forwards made several determined attacks, no addition could be made to the score. The home team, however, several times rushed away and put in some fine shots. Watson in goal, however, seemed equal to anything, and made some marvellous saves. Nothing more was scored by either side, and after playing for a short while in the encroaching darkness, time was called and Guy's retired defeated by 2 goals to 1.

Good play was impossible on account of the state of the ground and the high wind. The team, however, worked hard, and was only beaten by one goal, which was possibly an error of judgment on part of the referee. Wadson, in goal, played a magnificent game, and saved some very difficult shots. The defence was generally safe, and Corfe and Robson seem to be falling into each other's ways. Bacon, Shepherd and German make a splendid trio at half, and do a lot of work. The forwards worked very well, but their combination was not so good as usual, owing to the slippery state of the ground. Barber, Wiltshire and Norton play very well together. Team :—

GUY'S.—T. Wadson (goal); W. M. Robson, E. D. Corfe (backs); H. B. German, N. P. Shepherd, H. Bacon (half-backs); E. Edey, H. Barber, H. P. Wiltshire, E. Norton and F. B. Manser (forwards).

GUY'S v. OLD CRANLEIGHANS.

(GUY'S, 5 GOALS; OLD CRANLEIGHANS, 1 GOAL).

Played at Honor Oak Park on Saturday, Nov. 11th. Wiltshire won the toss, and our opponents kicked off against the wind. Guy's immediately commenced to press. After twenty minutes' play, Chignell obtaining possession, sent across a good centre, which Barber converted. Our forwards were now playing well together, the opposing defence being sorely tried. Wiltshire, with a good shot, scored a second goal, Barber quickly following with a third. Rain now began to fall heavily, and put an end to scientific play. However, Wiltshire scored again, Guy's leading at half-time by 4–0.

In the second half play was more even, Barber scoring for Guy's, and our opponents obtaining a goal from a mistake by Wadson.

The game thus ended in a win for Guy's by 5 goals to 1. The combination among our forwards was excellent, and quite overcame the Old Boys' defence. The halves and backs had very little to do. Manser came from forward to half, where he played a vigorous game. Team :—

GUY'S.—Wadson (goal); W. M. Robson, E. W. Corfe (backs); F. B. Manser, L. P. Shepherd, A. H. Smith (halves); T. Edie, F. Barber, H. P. Wiltshire, E. L. Norton, T. A. Chignell (forwards).

GUY'S 2ND XI. v. EVERSLEIGH.

(GUY'S, 3 GOALS; EVERSLEIGH, 1 GOAL).

This match was played at Balham on Saturday October 28th, Guy's, who were without Greenfield, Peall and Braithwaite, lost the toss, and kicked-off, playing with the wind in the first half. Guy's kept up a continual attack, and on several occasions were unlucky in not getting the ball through; the opponents' defence was fairly sound, and undoubtedly our weakness was

passing the ball too far in front. Rust, however, relieved us by netting the ball from a good centre by Dent, and half-time arrived with the score 1—0 in our favour.

On changing over, Guy's scored a second goal almost immediately after the kick-off, through a mis-kick on the part of one of their backs. Eversleigh were thus roused, their forwards began to play up a bit; our backs and halves were, however, not to be beaten. Bent brothers doing some good work, were especially noticable.

Guy's scored another goal from a good run on the right wing; both sides were beginning to tire, nothing else of note being done, till just on the call of time Eversleigh scored a lucky goal. Team:—

Guy's.—Wadson (goal); Leeming and Gromitt (backs); S. Bent, P. Bent and Morris (half-backs); Dent, Guy, Lacey, Roberts and Rust (forwards).

GUY'S 2ND v. OLD CRANLEIGHANS 2ND.

(Guy's, 5 goals; Old Cranleighans, 2 goals).

Played at Private Banks, Catford, on Saturday, November 11th, this match ended in favour of the Hospital by 5 goals to 2.

Guy's kicked off against a strong wind, and for some time play was even, until Morris opened our score from a centre by Peall. The Cranleighans equalized, but a nice run on the right wing by Dent, followed by a good centre, enabled us again to obtain the lead. Each team scored another point before the end of the first half, and Guy's crossed over leading by 3–2.

Rain fell heavily during the whole of the second half, and made the ball very greasy. Guy's, however, had much the better of the game, and scored two more goals.

Although evidently tired by his arduous duties, Greenfield showed his usual keenness by turning out and playing a good game at centre-half. Team:—

Guy's.—E. F. Heap (goal); H A. Watney, J. Braithwaite (backs); P. V. C. Bent, D. G. Greenfield, M. B. Taylor (half-backs); H. L. Dent, A. H. Turner, F. Morris, B. Rust, P. A. Peall (forwards).

"Hos.-Scho."

(GUY'S HOSPITAL OFFICERS' AND SERVANTS' CRICKET CLUB.)

THIRD ANNUAL REPORT.

Your committee have great pleasure in submitting the report of the third season. Nineteen matches have been played, eight of which were won, eight drawn, and three lost. 1,722 runs for 154 wickets have been made for the club, and 1,422 for 168 wickets by our opponents. The analysis shows that G. Arnold heads the batting averages with a total of 519 runs, and F. H. Bailey has the best bowling average, but it will be noticed that E. G. Copsey, the Captain, is only half a point behind him. The club prizes have, therefore, been awarded to Messrs. Arnold and Bailey.

An anonymous donation of one guinea was received during the year, for the purpose of instituting a Fielding Prize. The Committee received the rules governing this prize, and closely observed during the season the efficiency displayed by each playing member. Shortly after the termination of the season, this prize was awarded by the Committee to A. F. Causby, for the good all-round form he had shown.

The Club has to again acknowledge, with thanks, the substantial financial assistance provided by the members of the Staff, which enabled us to rent a private ground, and to renew our plant. We were also allowed to practice at the Students' Ground at Honor Oak Park, through the kindness of the Clubs' Union Council. Our best thanks are due to Mr. Harris for his invariable kindness in erecting our practice net, and preparing practice wickets.

Papers by Guy's Men.

The Pathology of Milk. By G. Leslie Eastes, M.B., B.Sc.—*British Medical Journal*, 11th November.

Infective Sarcomata in Dogs. By G. Bellingham Smith, M.B., B.S., and J. W. Washbourn, M.D.—*Ibid.*

Bacteriology of Rheumatic and Allied Diseases. By A. Stanley Wohlmann, M.D.—*Ibid.*

Appointments.

CIVIL.

Serjeant, Robert, M.R.C.S. Eng., L.R.C.P., has been appointed Assistant Medical Officer to the Camberwell House Asylum.

NAVAL AND MILITARY.

Staff-Surgeon W. W. Pryn, R.N., and Surgeon W. J. Bird, R.N., have been appointed to the *Minerva*, and Surgeon G. Burton-Brown, R.N., to the *Cambrian*.

Surgeon-Major E. T. Crouch, A.M.R., has been appointed to the Medical Charge of the troops at Forts Gomer and Grange and Browndown Camp.

PRESENTATION.

Dr. W. H. Bowes, Medical Superintendent of the Plymouth Borough Asylum, has been presented by the Staff of the Asylum with an electro-plated tea-kettle and table-stand, in view of his approaching marriage, as a mark of respect and esteem.

Birth.

HUNTLEY.—On October 29th, at Elist Park, Lewisham, S.E., the wife of Edgar Huntley, M.B., B.S. Lond., of a son.

Ed.—H. L. E.

Contents.

	PAGE
SUMMER DIARRHŒA IN CHILDREN: Clinical Lecture by Dr. Newton Pitt—*Continued*	497–503
ROYAL COLLEGE OF SURGEONS OF ENGLAND: Bradshaw Lecture	503
RENAL CALCULUS: Clinical Lecture by Mr. Davies-Colley	504–508
CHAPEL NEWS	508
PASSIM	509–511
CASE FOR DIAGNOSIS	511
"RELIGIO MEDICI": By Canon Taylor	511–513
PASS LIST	513
GUY'S HOSPITAL DENTAL SOCIETY	514–516
THE LESSONS OF THE DIRECT REPRESENTATIVES' MEETING AT NEWCASTLE	516
NURSING NEWS	517
THE SMOKING CONCERT	517
CORRESPONDENCE: Midwifery in General Practice	518
SPORT: Rugby Football—Guy's v. Bedford; Guy's v. Old Merchant Taylors; Guy's "A" v. Beckenham; Guy's "A" v. Old Merchant Taylors' "A." Association Football—Guy's v. Weybridge; Guy's 2nd v. Ewell 2nd; Guy's 2nd v. Central Technical College. United Hospitals Hare and Hounds—United Hospitals v. Wellington College	518–520
FROM THE GAZETTE'S SPECIAL PATHOLOGIST	520

Calendar of Coming Events.

December, 1899.

Sat. 2.—Messrs. Lucas and Lane's take-in; Drs., S. Hodgson and J. A. B. Hammond; Cl., E. C. Mullins.
1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I.—Blackheath, away.
II.—Polytechnic, away.
III.—Manor Way "A," home.
IV.—Streatham IV., away.

Mon. 4.—Exam. for M.D. and M.S. Lond. begins.

Tues. 5.—Exam. for B.S. Lond. begins.
Last day for sending in Fees and Certificates for 1st, 2nd and 3rd M.B. Camb. Exams.
Mr. Rowell's Demonstration on Anæsthetics, 12 noon.

Wed. 6.—1.15 p.m., Clinical lecture by Mr. Howse.
G.H.R.F.C., IV.—Merchant Taylors School III., home.
G.H.A.F.C., II.—City of London School, home.

Thur. 7.—Messrs. Golding-Bird and Dunn's take-in; Drs., H. Davies-Colley and P. T. Manson; Cl., E. Cohen.
January Appointment List closed.
G.H.C.U.—Address by W. McAdam Eccles, Esq. (St. Bart.'s Hospital).

Sat. 9.—1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., I.—Croydon, away.
II.—Croydon, home.
III.—Catford Bridge II., away.
IV.—Maze Hill "A," away.
G.H.A.F.C., II.—Old Foresters II., home.
G.I.P.P.S.—"Congenital Heart Disease," by H. S. French.

Mon. 11.—Cambridge 1st and 2nd M.B. Exams. begin.

Tues. 12.—Cambridge 3rd M.B. Exam. begins.
Mr. Rowell's Demonstration on Anæsthetics, 12 noon.
Meeting of the Dental Society at 4.30 p.m.
Exam. in Metallurgy for First Year's Prize, 2 to 4 p.m.

Wed. 13.—1.15 p.m., Clinical lecture by Mr. Howse.
Schedules for Final Conjoint Exam. to be left at the Medical School Office not later than this date.
G.H.R.F.C., II.—St. Bart.'s Hospital, away.

Thur. 14.—Messrs. Howse and Jacobson's take-in; Drs., H. G. Rashleigh and T. A. Matthews; Cl., J. F. Northcott.
G.H.C.U.—Address by T. Jays, Esq. (St. Thomas' Hospital).

Sat. 16.—1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., II.—London Irish, home.
III.—Hammersmith "A," away.
IV.—Mortlake St. Mary's, away.
G.H.A.F.C., I.—Idlers, home.
II.—Plumstead, away.

Guy's Hospital Gazette,

DECEMBER 2, 1899.

Summer Diarrhœa in Children.

CLINICAL LECTURE BY DR. NEWTON PITT.

October 14th, 1899.

(Continued.)

I will continue to-day the subject of Summer Diarrhœa, by first giving you brief notes of some cases of summer diarrhœa which have been under my treatment this year. There are two cases, that I will include, which were simple diarrhœa but not of the toxic form. By summer diarrhœa I mean the toxic fermentative form; while this is common in summer, occasionally cases occur in the winter.

The two following may be called simple diarrhœa. The first was a child of three years of age, attacked at the end of July. The child during the summer had had whooping-cough and measles, and had recently eaten some fried fish, which produced vomiting. The next day there was very severe vomiting and diarrhœa, and bright blood was passed in the motion. The child when admitted was extremely collapsed and pulseless, but after a hot bath and some stimulants it revived, and although the diarrhœa, with motions containing mucus, lasted for a few days, the vomiting soon ceased, and the child was quite well in a few days, the treatment being a diet limited to albumen water, and later on to milk, and after the first day or two an astringent aromatic mixture. This case of diarrhœa, which soon cleared up, started in a child that had recently

had a specific fever, and was due to its having been fed on fried fish, which in hot weather may have undergone some decomposition. That is a typical case.

The next was that of a child five months old, at the end of June. The child had been chiefly fed on cow's milk and barley water since he was two weeks old. He was constantly screaming, and suffered from vomiting; he was a very feeble, ill-developed child. The diarrhœa does not seem to have been started by any special indiscretion, but on its admission there was severe diarrhœa and vomiting, which lasted for some days. Although the diarrhœa and vomiting were checked, the child was subject to frequent recurrences, and it was nearly three months before the child was discharged well. Here there had been a long-continued period of malfeeding, and during the hot weather, an acute attack of diarrhœa and vomiting, which, although it quickly cleared up, was not for some time followed by satisfactory digestion. These are cases without complication.

I will now mention four cases of what we may call acute fermentative diarrhœa. The first was that of a man aged forty-one, in the middle of August, who without any obvious cause was seized with extremely severe diarrhœa. The motions were watery and very offensive; the patient only vomited once. He happened to have had fried fish and potatoes for dinner, but nothing specially to account for the attack. He was very collapsed, he was put in bed and starved. The diarrhœa cleared up in a couple of days, and the patient rapidly recovered. As usual in an adult, although an attack of summer diarrhœa may be very sharp, yet, provided the patient goes to bed and starves, the attack quickly passes off.

The next case was a child, one and a half years old, admitted on the 31st of July. The patient, a little girl, was backward with her teeth, but had no special indications of maldigestion. On the 23rd she was seized with vomiting and diarrhœa, which continued until the 29th. The motions were extremely fœtid and brown-coloured. On admission, the child was constantly screaming, the abdomen was rigid, the legs were drawn up, and in the evening the child had a fit. There was evidence of rickets. The child was given a dose of castor oil, and, except for albumen water, starved; and was then put on an alkaline aromatic mixture. Within two days the diarrhœa ceased and the child recovered. The temperature ran up to 100° F. This was a case of acute fermentative diarrhœa which cleared up at once under treatment.

The next was a man of twenty-one, who, on the 21st of August, was seized suddenly with vomiting and diarrhœa, which persisted. Cramps developed in his legs, and he complained, on admission, of a dry mouth and epigastric pain. he had a dose of castor oil, and later in the day an injection of morphia. Next day he was practically all right. There is no doubt that for acute summer diarrhœa in an adult there is nothing better than a laxative, followed, if the diarrhœa be very severe, by an injection of morphia. True cholera, never stops with an injection of morphia, but both acute summer diarrhœa and the more severe illness, English cholera, generally stop with it, provided you first give a dose of castor oil or some laxative to clear the alimentary canal of undigested food.

The fourth case is that of a baby fourteen months old. The rest of the family suffered with rickets, and were badly fed. The child was taken suddenly ill on the 17th of August, with green and very foul fermenting motions, and on admission was very collapsed. The rectum was washed out. A dose of castor oil was given, and he was fed on albumen water. Within three days the motions were more healthy, although they were still watery; the child was then put upon a mixture containing tannigen, was fed upon peptonised milk, and practically was well in about a week. In this case a badly-fed child had an acute attack of diarrhœa which cleared up under treatment within a week.

All these cases recovered. None of them were very severe, and there was nothing exceptional with regard to the symptoms or treatment.

The only fatal case was one of membranous colitis, which occurred in a baby seven weeks old. The child had been fed on cow's milk and water. On the 29th of January it had diarrhœa. The motions were offensive, green and watery. There was some rigidity of the abdomen; the child was extremely collapsed, and it had slight convulsive twitchings. On examination it was found that there was ulceration round the margin of the anus, and the appearances were somewhat suggestive of congenital syphilis. The bowel was washed out daily, the child was put upon albumen water and some somatose, but it died next day. At the autopsy we found widely-spread membranous inflammation involving the greater portion of the colon. There was such acute and severe inflammatory

mischief that it was impossible to save the child, and although the symptoms seem to have been quite recent, the mischief probably commenced some days earlier.

I might now refer to some other cases in order to illustrate the different points I want to bring before you. A child, eight months old, who had been taken acutely ill after being fed from a bottle in which the milk had been allowed to become sour, was taken to Margate by its parents. During the journey the child became very much worse, and when brought back was extremely collapsed, with profuse diarrhœa and vomiting. The temperature reached 102·8°. The child had some convulsive fits, the temperature ran up to 104·6°, and the child died. Post-mortem we found severe enteritis, mainly involving the duodenum, also broncho-pneumonia and pleurisy on the right side. The lung lesion is important, because there is no doubt that the broncho-pneumonia which develops with severe diarrhœa is often due to infection by the bacillus coli; this organism can be found in the sputum, and it is very often one of the potent factors causing death.

Another child, ten months old, had suffered from chronic diarrhœa on and off for a year. The child was admitted in the summer time, having had severe diarrhœa for the previous few weeks; it was extremely emaciated and died the same day. We found extensive atrophy of the mucous membrane of the bowel, with irregular patches of congestion.

Another child, nine months old, that had been fed on bread and condensed milk was taken ill and died from diarrhœa within forty-eight hours, having had watery and offensive green motions. At the post-mortem we here also found broncho-pneumonia.

Another child, nine months old, came in this summer with diarrhœa and vomiting for three days. The child was fed on albumen-water and peptonised milk; it appeared to improve at once. After a week, however, it became collapsed, the temperature run up to 107·2° F., and although the child was transfused it died, extensive enteritis being found.

These illustrate the chief varieties.

I propose, now, to pass on to a discussion of the TREATMENT. The treatment varies very much according to the severity of each respective case, but we will discuss the general treatment, and then the more vigorous measures which are necessary for urgent symptoms.

Prophylaxis.—There is no doubt that we are very much behind the Americans, and also the Germans, in not giving instruction to children, at school, on the suitability or the reverse of various foods, and through the Health Department to parents, on the necessity of avoiding all decomposition in the food of children, of insisting on regularity in feeding, and pointing out that when the weather is hot, children do not require so much food as when the weather is colder. In New York the authorities send out, before the onset of hot weather, pamphlets giving instructions of that kind, and I think this is a plan that ought to be followed out here. In the pamphlets would also be included instructions as to the general causation and treatment of diarrhœa. There is no doubt that the most important cause is the decomposition of food. I was pointing out, in my last lecture that milk will go bad within a very few hours when the temperature is over 60° F.; the milk will almost certainly be sour within eighteen hours; whereas, when the temperature is lower, milk will keep thirty to forty hours before it goes bad. Hence the importance, when the temperature is high, of taking exceptional care, and it cannot be too strongly insisted upon.

When the parents can afford it, children, especially for the first two years of life, ought to be sent out of town and kept at the seaside or in the country during the summer. The great mortality from summer diarrhœa is in children during their second year, and in towns.

Care should also be taken to avoid chills, particularly when the changes in the weather are very sudden. Many attacks of diarrhœa come on with a sudden fall of temperature.

Not only is it necessary to avoid all uncleanliness with regard to the vessels used for milk, but it is most essential that in summer weather the milk should be sterilized. In hot weather children need more water and less solid food; it is also desirable that children should not be allowed to have uncooked fruit during very hot weather, because it is very apt to decompose. Most cases of diarrhœa, if treated at once, get well. The cases that die are those which are allowed to run on unchecked. Very often parents think that when a child is teething it is unwise to stop diarrhœa; this is an error, and if the diarrhœa is allowed to run on in hot weather, the illness may become very serious.

These prophylactic measures in most cases suffice to prevent serious illness.

When a child is seized with diarrhœa, the first thing is always to put the child to bed and keep it warm. Many attacks of diarrhœa will at once pass off, if the child is kept in bed,

which would persist if the child is allowed to be up.

It is most essential to have a well-aired room. You will find that attacks of diarrhœa are most common in small tenements. Here, when a child is taken ill, it is generally kept shut up in a stuffy room until the air becomes so foul as to largely militate against its recovery. You cannot have too much fresh air for these patients. In the summer time, after the acute symptoms have passed off, if the child does not quickly improve, it is always desirable to put it in the open air, on a couch, well wrapped up, in the garden under the trees, when it will often, in the fresh air, make rapid progress to recovery.

Scrupulous cleanliness also is essential, because there is no doubt that the fæcal material that is passed is infective, and may infect other children, consequently all fouled napkins, &c., should be put at once into an antiseptic solution.

It is important to keep the abdomen warm. There is nothing better for this purpose than a cotton-wool binder applied over the abdomen during the illness.

Food.—The main line of treatment is to at once stop all milk, and to keep the patient more or less on a starvation diet for the first twenty-four hours. Many attacks of diarrhœa will at once get well without any further treatment. Suitable food is much more important than drugs.

If the vomiting is very severe it is better to give the child nothing else but water which has been boiled. Infants readily suffer from the deprivation of liquid, but provided you give a child water to supply the waste from the diarrhœa the child will not hurt if it has no other food for twenty-four hours, unless it is an extremely feeble child, when it may require some stimulant. If, however, the vomiting is not very severe it is best to feed the child either on albumen water or on mutton or chicken broth. The albumen water is made by mixing the white of an egg with half a pint of water, and straining; allow the child to have only a small quantity at a time. If you find that an ounce makes the child sick you must reduce the quantity. If you find that the child cannot retain a tablespoonful of albumen water, dilute with water and reduce the amount. If the child is sick the fluid will help to quench its thirst, and that is better than nothing. Beef-tea has a greater tendency than chicken broth to keep up diarrhœa on account of the salts it contains.

Another food which is very valuable is whey, made by adding rennet to warm milk and straining it. The albumen in whey is very small in amount, and therefore the child is better able to digest it. Still, when the weather is very hot, and the attack very severe, it is perhaps wiser to avoid even whey at the commencement. If the child has done well on albumen water and chicken broth for two or three days you can then give whey, and if you want to make the whey more nourishing add to it the yoke of an egg or Mellin's food. If the child is extremely collapsed and feeble it is necessary to give a *stimulant*. White wine whey is the most valuable form in which to give stimulant, and, for people who can afford it, the finest stimulant is undoubtedly a very old sherry; there is no stimulant to equal it for young children. A wine-glass of sherry is added to half a pint of milk, then the whole is boiled and strained. You can also give brandy. In some cases a child will take half an ounce or an ounce of brandy every twenty-four hours. When the child is very feeble and collapsed you should give the egg and brandy mixture of the British Pharmacopœia.

This diet is suitable for two or three days; when you begin to increase the food you want to be very careful that you do not give the child a milk diet containing too much albumen. Cow's milk contains about four per cent. of albumen, and when you commence again with milk it must be diluted; one part milk to four parts water is sufficient to start with. Gradually increase the amount of milk, and then add by degrees the elements of the child's ordinary diet. Amongst meat preparations which are useful, Bovinine and somatose are two of the best. For children, over a year old, scraped meat is a very useful diet, particularly if the diarrhœa tends to become chronic. If at the end of a week the diarrhœa is not improving, and the child's strength is likely to fail, it is best to give up milk foods, and to feed the patient on pounded meat which has been rubbed through a sieve. The essential thing is to avoid milk in the early stage, and when you do give milk, be careful that both the milk and water have been boiled so as to reduce the tendency to fermentation changes.

With diarrhœa you sometimes have foul and sometimes acid, sour motions. It has been suggested that when you have acid motions the fat in the milk should be cut down, and when the motions are foul cut down the albumen, thereby you prevent, on the one hand,

acid, and on the other, proteid fermentation. But the question is still an open one.

Replacement of fluid lost.—In acute cases the appearance of the child rapidly changes; the face becomes sunken, the nose pinched, the skin inelastic, the body seems to waste, and a child may lose some ounces in weight in a couple of days. If you allow this severe condition to continue, the child passes into a state of collapse, and unless you check it, it is sufficient to kill the child. Give the child water by the mouth if it is able to retain it, but supposing that on account of vomiting it cannot do that, you must then supply the fluid by the rectum. In urgent cases it is desirable to wash out the rectum once daily, and you can leave a certain amount of the fluid behind, which is very quickly absorbed. During the last two or three years many cases of infantile diarrhœa have done extremely well with *subcutaneous injections* of saline fluid, a drachm of salt to the pint. Even in infants you can inject four ounces into each axilla, and repeat it twice in the day. By injecting fluid which is rapidly absorbed you raise the blood-pressure, and the nourishment of the child is kept up. Unless you have a fair blood-pressure absorption from the stomach ceases, and so the child will have no chance of absorbing any nourishment. The simplest method is to use a Higgenson's syringe, to which is attached by an indiarubber tubing a small pointed canula from an aspirator. The whole is to be boiled before use.

In some cases we have tried *injecting serum* subcutaneously, ten or twenty centimetres at a time. This has also been used by Ranke and others. No ill results have been observed. If the child is so ill that it is unable to take any nourishment at all, I doubt very much whether a subcutaneous injection of serum will save it. However, it is worth bearing in mind that if you cannot get nourishment into the body in any other way, you can introduce it subcutaneously.

Antitoxic serum.—I may also refer to treatment, which has been carried out by Lesage, of injecting the serum of animals which have been immunised against the bacillus coli. The poisoning in these cases is by no means always with the bacillus coli, but in many this bacillus seems to be largely responsible for the toxic symptoms. Animals were immunised against the bacillus coli, and their serum used in cases of summer diarrhœa. The serum was injected in fifty-two cases; in half of them the symptoms ceased in forty-eight hours, fourteen more improved and were quite well in six days, but twelve showed no improvement. I do not know that the treatment has been carried out in England.

As to the best means of emptying the stomach and intestines of their contents, when the motions are very frequent or very foul there is no doubt that you improve the child's condition and you retard the frequency of the motions by *washing out the rectum.* Generally here we use a comparatively small amount of fluid to wash it out, probably twelve or fifteen ounces, but in America the custom has been to use from two to four quarts of water, and they say that they get better results than with small injections. The simplest way to carry it out is to have a soft tube attached to a funnel, and, putting the child in a horizontal position, with the buttocks slightly raised, insert the end of the tube into the orifice of the anus and allow the fluid to run. You will be able gradually to pass the tube to a distance of eight or ten inches into the colon, and in the course of two or three minutes one pint of the water will have passed through the tube, and a couple of pints by the time that six minutes have elapsed. Provided you do not hold your vessel more than two feet above the anus, you need have no fear of doing any harm. The fluid flows in and you may massage the abdomen slightly to assist its passage. As soon as the colon is full, the water will be ejected by the side of the tube on to the mackintosh and be conveyed into a pail. In that way you do not disturb the child much, and you can clear out all the contents of the colon. Under no circumstances does fluid pass above the ileo-cæcal valve. The most essential element is the water. It does not make very much difference what you add. A saline solution, a drachm to a pint, answers very well. I have generally used cinnamon water, which, when it remains behind, more or less retards decomposition. Various antiseptics also have been used, such as boric acid, formalin, salicylic acid.

Temperature of the fluid injected into the bowel.—You will find that a temperature of about 100° is the most satisfactory for washing out the bowel, but if the child has a temperature of 103° F., you may bring that down by using cold water for the injection. If the child is extremely collapsed and ill, you may stimulate it by using water of a temperature of 108°. So that you should vary the temperature according to the condition of the child. Occasionally some collapse is produced by the washing out, and therefore it is always desirable to give the

child a little stimulant either by the mouth or subcutaneously before the injection. Be careful not to allow the child to get chilled while the process is going on. The giving of a stimulant just before the injection, I am sure, is valuable, and in all severe cases, where the diarrhœa is frequent, should be carried out.

Lavage of the stomach.—I must say that I have not adopted the plan myself, and it seems to me that it is not very often indicated. But extremely good results have been reported, especially where the vomiting was persistent. Persistent vomiting it is said can very often be checked by washing out the stomach. The great point to be observed in washing it out is to pass the tube quickly over the pharynx, because it is touching the pharynx that tends to make the child retch.

To reduce the temperature of the body.—In the ordinary forms of acute fermentative diarrhœa and simple diarrhœa, the temperature is raised only a degree or so, and no special treatment is required. But in the inflammatory form the temperature may run up to 107° or 109° in fatal cases. Dr. Eustace Smith records the case of a child in which the temperature was over 109°, and which finally recovered. So that it is most important to reduce the temperature when it is above 103°. If the child is very feeble and collapsed a wet pack is sufficient, or an ice compress on the abdomen has often proved satisfactory. In the great majority of cases a bath, started at a temperature of 80° or 90°, and cooled down with water, is a much more efficient means to employ if the bodily temperature is very high. The method of injecting ice-water into the rectum is more dangerous than that of the bath.

Collapse.—This is due to two conditions; it may be due either to very low arterial pressure, in which case you deal with it by subcutaneous injection of saline liquid; or it may be due to toxæmia; it then requires vigorous treatment. If the child is not stimulated it becomes more and more collapsed and comatose and dies. If the child is not extremely ill, a hot mustard bath is an excellent stimulant and improves the patient's condition very much. But you can also get a stimulating effect in the same way by putting a mustard poultice on to the chest and abdomen. Make up a poultice of about one part of mustard mixed up with three of flour, put it on for five or ten minutes and repeat every two hours. This will quickly make the skin red and act as a vigorous stimulant, improving the child's condition very greatly. Or you may employ another method. Give the child a wet pack with mustard water. Put two tablespoonfuls of mustard in a pint of hot water, wring out the fomentations and apply them on the chest and abdomen. This is an efficient stimulant. In mentioning food, I referred to white wine whey, and also to the egg and brandy mixture, both of which are of great value, and absolutely necessary in these cases of collapse.

Drugs.—I have left this to the last, because on the whole you will find that drugs are the least important part of the treatment. Unless you stop the admission of decomposing food into the alimentary canal, and unless you reduce the temperature and treat the collapse, you will find that there is no field for your drugs.

With regard to the initial treatment with drugs. In most cases the diarrhœa commences with the passage of undigested food, and at this stage there is nothing better than a dose of castor oil; one to two drachms for a small child, and a tablespoonful for an older child. When there is much vomiting with the diarrhœa, the best drug undoubtedly is calomel. Nothing stops the vomiting more satisfactorily; give it in a dose of one-fourth or one-sixth of a grain every two hours until the child has taken a couple of grains. In ordinary cases the customary powder of bicarbonate of soda with five grains of rhubarb is a useful one; mixed up with a little glycerine, this is sufficient to remove any undigested food which the alimentary canal may contain. The first thing then is to give a laxative to empty the alimentary canal of decomposing food.

When the diarrhœa persists, if you still have undigested food passing—which ought not to be the case if you have stopped all milk—or when there is much mucus in the motions, with tenesmus, there is nothing better than a castor oil emulsion—

℞ Ol. Ricini	...	ʒiv.
Pulv. Tragac. Co. ...	...	gr. xx.
Glusidi	. .	gr. ⅛.
Aq. Anethi, ad ...	...	ʒij.

one to two teaspoonsful three times a day; or, small dose of Dover's powder, quarter to one grain according to age, and half a grain of Grey powder, every six hours.

On no account give any astringent or opium at the onset of an attack of diarrhœa. Always wait a short time before you start with astringents. After a laxative for the mild attacks, a useful prescription is an alkaline and aromatic mixture—

℞ Sp. Ammon. Aromat. ... ℥iii.
Tr. Card. Co. ... ... ℥vi.
Tr. Zingiberis .. ... ℥vi.
Aq. Carui, ad ... ... ʒj.
6tis horis.

As soon as the motions improve—and the appearance is of more importance than the consistency—and as soon as the temperature is down, then you may give astringents and opium; but if you give opium when the temperature is high, it will probably rise still more. To a small baby you may give half a minim of the tincture of opium and a little catechu or hæmatoxylon, and if not sufficient the dose may be gradually increased.

In the more chronic cases astringents are especially useful, and amongst the best is tannigen. The tannin it contains is only liberated on coming into contact with an alkali, and therefore it does not upset digestion. In chronic cases it is extremely useful, and may be given while the diarrhœa lasts to a small child in doses of eight or ten grains frequently. Another useful drug is ipecacuanha. It is particularly beneficial where the vomiting is very severe, in which it is given in very small doses of one to three minims of the vinum. Where you have much tenesmus and inflammation of the colon, you may give larger doses; you may give one-eighth of a grain of the powder in an emulsion, and when there is much mucus passed you may give a dose of one grain or more, which, although it may make the child sick, will greatly improve the condition of the colon; or five grains may be given as an enema with starch. Opium may be given cautiously by the mouth, either in the form of Dover's powder, or of tincture of opium. With frequent small motions and an irritable condition of the bowel, give by enemata three drops of the tincture of opium with a little chalk in starch mucilage. In the condition known as cholera infantum, that is when there are very profuse vomiting, watery motions, and profound collapse, you will find the most valuable drug is morphia given subcutaneously; $\frac{1}{100}$ to $\frac{1}{30}$ of a grain to a small child will very often stop the vomiting and diarrhœa better than any other treatment.

Antiseptics.—When the motions are foul or fermenting; after a laxative, an antiseptic mixture should be given. Many antiseptics have been tried, but not always with satisfactory results, such as carbolic acid, perchloride of mercury, creosote, salicylate of soda, B. naphthol, &c. One of the most useful is carbolic acid, which may be given in doses of one to five minims of the glycerine of carbolic acid every two or three hours. Of the perchloride of mercury one-fiftieth of a grain given frequently is also recommended, but it should only be continued for two or three days. One-fiftieth of a grain of perchloride of mercury and one grain of chloral, repeated every two or three hours, for a day or two, will enable seven-eighths of the patients to recover within two or three days, Dr. Lupp states. While it is very often desirable, particularly if the motions are very foul, to give some antiseptic, still there is no single antiseptic which has shown its decided superiority to the others.

Syrups should not be used to flavour mixtures in diarrhœa, but gluside or glycerine should be employed instead.

As the child gets better there is a great tendency to relapse, and a very slight change of temperature—merely exposing the child for some time while it is having its bath—is sufficient to keep up diarrhœa for weeks or months. Too great care cannot be taken to avoid chills. In such cases the castor oil emulsion, given from time to time, is valuable. An alkaline aromatic mixture is indicated at the beginning, but when the condition has become chronic, probably an acid aromatic and astringent mixture is preferable.

For *vomiting* the most useful drugs are calomel in minute doses, ipecacuanha, and tincture of iodine.

We have discussed a number of points. The general principles which underlie the treatment are not very complex. They are—keep the child at a uniformly warm temperature in fresh air, stop all fermented food, do not be in any hurry to feed the child, give a laxative and then antiseptic drugs, and do not be in too great haste to give opium and astringents in order to try and check the diarrhœa.

Royal College of Surgeons of England.

BRADSHAW LECTURE.

Notice is hereby given that the Bradshaw Lecture will be delivered in the Theatre of the College by Henry G. Howse, Esq., F.R.C.S., on Wednesday, the 13th of December next, at 5 o'clock p.m. precisely. The subject of the lecture will be "A Centennial Review of Surgery." Fellows and Members of the College are invited to attend. Students and others, who are not Fellows or Members of the College, will be admitted on presentation of their private visiting card. EDWARD TRIMMER,

15th November, 1899. Secretary.

Renal Calculus.

CLINICAL LECTURE BY MR. DAVIES-COLLEY.

October 25th, 1899.

GENTLEMEN,—Under my care, during the past year, I have had two patients with suppurating kidney, caused by the presence of stone.

The first of these was a woman, aged forty-two. She came in under me, in November of last year, for discharging sinus over her right kidney. She was a married woman and had been, four years ago, in University College Hospital, and the Surgical Registrar of that hospital has kindly sent us the notes stating what her condition was when under them. She was under Dr. Ringer from May 19th to June 5th, 1894, for tenderness in the right side of ten years' duration, and for an enlarged and tender liver, reaching to within two fingers' breadth of the umbilicus. She was discharged, relieved of the pain, and with the liver at one finger's breadth higher than on admission. She was readmitted, under Mr. Godlee, on July 11th, 1894, and discharged on August 23rd, 1894. She complained of great pain in her back on the right side. There was a rounded tumour in the right loin, and a considerable amount of pus was found in the urine. Under an anæsthetic, exploration showed the condition to be due to "perinephritic abscess, calculous pyelitis." The calculus was removed from the abscess cavity. Then there is a description of the calculus, it being rather like a small blackberry. She was admitted again at the beginning of the next year for sinus following the nephrolithotomy. A small calculus was again removed, and the woman remained quite well until the summer of last year. She was then in domestic service in the country as a cook. Three weeks before she came under my notice she suffered a great deal of pain on her right side. An abscess formed, and was opened before she came under my care. When admitted she was passing a small quantity of pus in her urine, and there was a deep sinus discharging in her loin at the cicatrix of the previous operation. I made a large incision, and when I had with considerable difficulty dilated the thick walls of the sinus, I could get my finger into a cavity from which I removed a rough oxalate of lime stone more than three-eighths of an inch in diameter, very like a blackberry in appearance; and from another cavity I took three uric acid calculi of a smaller size; they had been lying in a cavity together and so had produced these facets (as shown) upon each other.

In regard to this case, I do not think this was the best treatment that could have been employed. I believe it would have been better to have excised her kidney, but I mentioned this to her before the operation, and she was quite determined that she would not have so severe an operation performed upon her. She quite recovered and went back to her work, and remained in good health up to a month or two ago, when I heard that she had had some more suppuration. I think it is quite likely that there are more calculi in parts of the kidney which I did not succeed in reaching, and that she will have some more trouble.

The other case was a woman, aged twenty-two and married, who came under my care on August 16th of this year, with a sinus in her right lumbar region. According to the report, "When the patient was twelve years old she had an operation on her back passage for her kidneys." I do not know exactly what is meant by this. It would appear, however, that she had some kidney affection then. In August, two years ago, she was confined of a dead child. Puerperal convulsions came on about twenty-four hours after confinement and lasted for some days. Ten days afterwards she complained of pain in the right side, and a fluctuating tumour was felt there. In September, 1897, she was operated on at the Croydon Hospital, and two abscesses, each containing a calculus, were opened. These were taken out and the patient remained at Croydon Hospital as an in-patient for five months. "Pus remained in the urine, but has diminished lately in quantity. A fortnight ago a cystic tumour connected with the kidney was found by her medical man. She herself noticed the lump about six months ago."

From the history it seems probable that the patient has had calculi in her kidney for a good long time, very likely from the time she was operated on at the age of ten years. In consequence, however, of septic organisms in the blood after her confinement, it would appear that the kidney trouble became worse and that an abscess formed. Although the abscess was opened and two calculi removed the wound never healed. When she came in the patient looked rather pulled down. She had a sinus in her loin and there was pus in her urine. I examined her vagina and found that the lower end of the right ureter was enlarged, and she complained of tenderness there. Under an anæsthetic I made a large incision in her lumbar region, and soon came upon the dilated remains of the kidney. With a little difficulty I managed to get between the kidney and its

capsule, and slowly separated the very much distended kidney from the soft parts around. It was a difficult operation, the kidney being so enlarged and as a result tightly pressed against all the parts around. But after tying the renal vessels I removed the kidney, and here is the tumour (produced) very much shrunk, and here is one of the calculi which were contained in these cavities of the much dilated pelvis. As far as I could find on examination there was hardly any proper renal tissue; it was a mere bag of pus with very little secreting structure in its walls.

I will now proceed to the subject of renal calculus generally.

Renal calculi occur at any period of life, and in either sex. You know that vesical calculi are comparatively common in young children and in people after the age of fifty or sixty. So it is with regard to renal calculi for the simple reason that most of these vesical calculi begin as renal calculi which come down to the bladder a short time after they have formed in the kidney.

The most common renal calculus is that composed of uric acid; the next in frequency consists of oxalate of lime; and you also get phosphatic calculi in the kidney usually upon the nuclei formed by uric acid, or possibly by oxalate of lime. These calculi are very varying in appearance. The oxalates have usually a dark purplish colour, and I described the calculus in one of these cases as having the appearance of a blackberry. But we should be prepared for this possibility—that when these calculi are small they are very often quite different in appearance. Twice in the last year I have had nearly white renal calculi brought to me by patients, and they have been found on analysis to be composed of oxalate of lime. An ordinary oxalate of lime crystal is as clear as glass, and you would therefore expect the calculus composed of these crystals to be nearly white. The reason why oxalate of lime calculi, both of the kidney and the bladder, acquire that curious dark colour is that they cause a good deal of irritation and bleeding in these organs. After a time some of the elements of the blood get incorporated with these white crystals and give the calculus its mulberry appearance. The uric acid calculi are easily recognised by their russet-brown colour and the phosphates by their chalky whiteness.

The causes of renal calculi are somewhat doubtful. They are much more common in certain districts, probably on account of the particular climate, or of the food which people take. Something is wrong in the assimilation of the food, and certain salts, on account of their not being thoroughly dissolved, are deposited in the kidney instead of being voided with the urine.

Later on in life a great number of these calculi are due to a gouty condition. In such patients there is a deposit of urate of soda in the joints, and uric acid crystals are at the same time apt to accumulate in the kidneys.

Now as to the symptoms of these calculi. They are not very easy in many cases to diagnose. We are apt to make mistakes and think perhaps that we have got a case of tubercular disease of the kidney, whereas it turns out to be stone; or we may think it is a case of stone, and it turns out to be tubercular disease. It also not infrequently happens that you cut down on the kidney thinking to find a stone, and you find no trace of one. That happened to me this year in the case of a girl of twenty-four, who was thought to have renal calculus in her left kidney. I had the kidney out on the loin and examined it very carefully; I handled it all over, pricked it in various positions with a needle to find out if there was any stone, and finally made an incision into it and explored the pelvis and calices without finding one. The wound healed up rapidly and her pain had completely gone by the time she went out of the hospital.

The first symptom is a dull aching pain across the lumbar region, more distinct usually on the side specially affected by the stone, but by no means confined to it, a pain running down the groin, and worse when the patient rides about or takes outdoor exercise, or is playing a game, such as lawn tennis. Patients are liable also to exacerbations which are known by the name of renal colic, in which case in the male you generally have pain extending from the kidney behind and above right down to the bottom of the testicle. You will easily understand the locality of these pains if you consider how close the origin of the renal artery is to that of the spermatic artery in the male and the ovarian in the female. There is, therefore, a very intimate connection between the plexus of nerves which run along the renal artery and supplies the kidney and ureter, and the plexus which runs down to the testicle in the male and the ovary in the female.

You may be asked, Which would be likely to cause the greater pain, a small or large stone? Probably the small stone, as it is more movable and from time to time lacerates or compresses

the tender structure of the kidney, and sometimes also slips down into the upper orifice of the ureter, so as to obstruct the flow of the urine. But a large stone is often so grasped by the pelvis and cortex that it cannot move. Here is a large branching one from a woman of forty-two. My notes do not mention that she had any pain. She came to us because she suffered from frequent passage of her water. She used to get up five or six times every night to pass water, and she was always passing pus in her water, and also was getting thinner. Whereas these smaller smooth stones were from a nurse who was utterly unable to do her work because of the severe pain which she suffered in her loin.

After a time, also, patients are apt to get a good deal of pain at the neck of the bladder, and with this there is frequency of micturition, so much so that sometimes you are inclined to diagnose vesical calculus.

You must next enquire about and examine the urine. Blood is not passed in every case, but it is frequently a symptom of the presence of stone in the kidney, and later there is often pus.

When blood is found in urine it may be due to a great number of causes. The first thing you have to do is to find out where the blood comes from. Does it come from the kidney, or the bladder, or the urethra? I suppose most of you know that the ordinary distinction is this: if it comes from the kidney it is very intimately mixed up with the urine; the urine looks quite uniform, and is of a dingy, brownish-red colour. If the blood comes from the bladder the patient usually passes clear urine first, and then blood. If the blood comes from the urethra the patient passes blood first and then clear urine. That is the clinical distinction in making the diagnosis in these cases. But it does not always hold good. In some cases you are somewhat uncertain. Supposing a patient has got a quantity of blood in his bladder, you very often find it quite mixed up. Still, in that case, if you talk to the man he will generally give you a history of times when he passes rather less blood in his urine. Supposing that you ask him whether he ever passes partly clear water and partly blood at the same time, he will probably tell you, "Yes, sometimes," when he is not passing very much blood. Then you should ask him which comes first, the clear water or the blood? That will help you in patients who, at the time you see them, are passing a quantity of blood which you find is intimately mixed up with the urine. If the urine contains clots their shape may help you to determine the source of the hæmorrhage. Clots from the kidney may indicate by their triangular shape and branching outline that they have been moulded in the pelvis and calices. I have found this useful after injuries to the kidney, but do not remember to have received help in this way in the diagnosis of calculus.

Blood from the kidney, of course, does not necessarily imply that the patient has stone. It might be due to tumour of the kidney, but in that case you have a rather short history, and you can feel a great swelling. It might be due to tuberculous disease of the kidney, and that is the chief difficulty that we have to surmount. It is very difficult to say whether a patient has stone in the kidney or tubercle. A strong, healthy man came under my care a year ago. He was twenty-six years of age, and gave a history of passing blood in his water. He had a certain amount of lumbar swelling, and great pain passing down his groin, and he was much worse after walking about. And so it seemed in that case pretty certain that he was suffering from calculus in the kidney. I cut down upon his kidney and examined it carefully with a needle, and found a gritty patch at the top of the kidney. I cut into this and found some calcareous material which I concluded was tubercle, and scraped it away. I found no stone at all. The patient was not at all relieved by the operation, but suffered more from pain and frequency of micturition, passed a quantity of pus, and finally had lung trouble; and eight weeks after the operation he died. We found he had miliary tuberculosis. Again, I had in my ward a short time ago a thin, pale boy, fourteen years of age, who came under my care for tuberculous disease of the kidney. He was passing blood and pus, and also had frequency of micturition, and there was tenderness in the lumbar region. I cut down upon his kidney, and found in the upper part of it a stone about half-an-inch in diameter, weighing twenty-three grains. I removed it, and he recovered perfectly, and went out within a few days after the operation.

Of course, in many of these cases you get help by finding out some other evidence of tuberculosis, the patient, for instance, being perhaps more wasted than the amount of blood which he has lost from renal calculus would account for. Again, you ought to look for signs of tubercle in the genito-urinary tract. Examine the testicles and see whether the patient has got enlargement of the epididymis and vas deferens. In the female you should

pass your finger into the vagina and feel if the lower part of the ureter is swollen and tender, for tuberculous disease of the kidney is apt to run down the ureter. Again, we may examine the bladder with a cystoscope. In one case I saw, with the help of the cystoscope, around the orifice of the left ureter a large patch, which I thought was a tubercular ulcer, and that being the case, the tenderness and swelling in the left kidney was most likely tubercular. I cut down on this kidney and found the case one of tubercular disease, which soon proved fatal.

Blood may also be due to other causes, such as nephritis. In such cases, however, there would be high temperature, œdema, and other symptoms indicative of renal trouble; sometimes also desquamation of the skin, as in nephritis from scarlet fever. Or, if you examined the urine microscopically in these cases you would see very likely casts of the tubules, showing that the patient has acute nephritis. If there is pus in the urine you should be careful to examine whether the urine is acid or alkaline. Acid urine containing pus is most often from the kidney, whereas alkaline urine containing pus is most often from the bladder. Again, the microscope will tell you whether a patient is passing uric acid or oxalate of lime or phosphates (old renal "or phosphatic crystals.")

The next thing you have to do in these cases is to examine the kidney itself. In some cases, by no means in all, you will find that the kidney itself is enlarged. You may find also that it is tender. Another thing which you do generally in these cases is to put your fingers upon the kidney and, as you are feeling it gently, to give a sudden impulse so as to drive the soft parts against the kidney. Sharp pain produced by such pressure is an important indication, though not absolutely conclusive, of stone in the kidney.

Then, of late we have also examined these cases with the X-rays. I cannot say that my experience has been very satisfactory with this method. If the patient is thin oxalate of lime stone generally shows fairly well, phosphatic not quite so well, and uric acid stone hardly at all. The lecturer then related a case in which he had used the X-rays without success, although there was no doubt that a small oxalate of lime stone had been present for some time. The patient suffered from severe renal colic, and afterwards passed the stone *per urethram*.

But I think it is desirable in these cases to use the Röntgen rays; several cases are now reported in which the exact position of the stone has been indicated by it.

Now comes the treatment, for the discussion of which I have very little time. In the early stages of the affection I think there is a good chance of the stone coming away and being got rid of. Under these circumstances you do not operate at once. You tell the patient to be careful what food he takes and what drink he takes. He should not take very much nitrogenous food, but he may take meat once a day. Then you should give the patient a good deal of distilled water to drink. This can readily be procured in an effervescent form so as to be quite palatable. He should also take a small quantity of alkali, such as citrate of potash, in the course of the day. Moreover, he should keep his bowels open. By these means a deposit of any more calculus will probably be prevented, and I think there is very good reason to expect that you will diminish the size of the calculus and facilitate its passage along the ureter.

You may have to treat the patient during an attack of renal colic. The patient has severe pain all over the abdomen, running down from the kidney to the testicle. He is doubled up, he may roll on the floor with severe pain, he has a quick, hardly perceptible pulse, and beads of sweat standing out upon his face and forehead, and is in a state of the most severe collapse. He may even vomit with the pain, which, I suppose, is as severe as it is possible to endure. There is generally frequent micturition, but only small quantities of urine, usually stained with blood, can be found. The attack may last for several hours or even days. You must allay the pain with opium or injections of morphia, while the peristaltic movement of the ureter is forcing the stone downwards. I should also apply heat locally by means of large linseed poultice, or an indiarubber hot water bottle, to the neighbourhood of the kidney. On the other hand, some patients are more relieved by the application of an ice-bag. In some cases the surgeon may have to give chloroform on account of the excessive pain, and when this is the case, gentle massage may be applied downwards along the course of the ureter so as to promote the passage of the stone onwards into the bladder.

Then, what may happen in these cases? Usually the stone gets into the bladder, and it may stop there. In the female it is sometimes passed without notice, because the female urethra is short and broad, and the stone may be got rid of when the patient is at the closet,

and the stone not be found. But in the male if the stone is passed by the urethra it is generally noticed, and the patient brings the stone for you to look at. But it does not always follow that the stone will pass the urethra; it sometimes will stop in the bladder, and sometimes in the prostate. Sometimes it drops back into the kidney, and sometimes the pain may cease and the stone remain impacted in the ureter. In that case the patient will probably get later some structural change in the kidney, such as hydronephrosis or atrophy.

I had a patient not long ago with a calculus that had stopped in his prostate. He was fifty-seven years of age and had suffered from this stone for some time. He was out one day bicycling, and after he had travelled twelve miles he was attacked by severe pain and a great desire to micturate, but was only able to pass a small quantity of urine on each occasion. He suffered great pain about the neck of the bladder, and after a time he could not pass any water at all. He sent for a doctor, and the doctor tried to pass a catheter, but could not, and he said the patient had stricture. The doctor brought him to see me in town, and I found on passing a good-sized sound that it went in easily. When it was passing the patient's prostate I felt something gritty; I then passed a silver catheter and drew off fifteen ounces of high-coloured urine. I could not feel a stone in the bladder, but only this gritty substance at the neck of the bladder. I arranged to give the patient chloroform and explore for the presence of stone, but, fortunately, the next day, or two days afterwards, he passed a small oxalate of lime calculus the size of a small pea. The stone, I suppose, had gone down the ureter into the bladder and then become impacted in the prostatic urethra.

I had intended to speak of the operative treatment of these cases, but I have only time to mention a point of some interest in connection with one of the patients whose case I have read, viz., the woman with calculous pyelitis, whose kidney I removed after ascertaining from the amount and composition of the urine which she was passing that the other kidney was healthy. A curious accident happened in her case, which shows how careful we ought to be in applying our ligatures. After cutting down upon the kidney I put a silk ligature on the vessels, and when I had tied this ligature I pulled it a little out so as to examine the pedicle. I found there was a small fold of membranous tissue included with the vessels, so I put another ligature on the vessels about half-an-inch further from the aorta and the vena cava inferior than the first ligature. When I had tied this I cut away everything beyond. Then I examined the first ligature, and, as I was quite uncertain what this fold was, I cut through my ligature, and, as far as I could see, the ligature had done no harm at all. But four days after the operation it was noticed that the discharge became very foul, and the patient was evidently passing fæcal matter through the wound. This continued for ten days and then stopped. What had happened was this: I managed in my ligature to include a small portion of the ascending colon. You see it is in very close relation with the front of the kidney, and in this case it was, no doubt, adherent to the inflamed walls of this dilated kidney. It is interesting to notice what happens in consequence of such an accident. Probably the temporary constriction caused a small slough which perforated the wall of the intestine and gave rise to the fæcal fistula. In such a case it is best to leave things alone and wait, because if there is only a small perforation of the intestine, as soon as the granulation tissue begins to contract it gradually closes the hole until it is entirely shut up and no more fæcal matter comes.

Chapel News.

The second of the series of lectures to medical men will take place in the Chapel on Monday, December 11th, at 5 p.m. Mr. George Russell will be the lecturer.

A course of instructions will be given in the Chapel on the Tuesday evenings in Advent at 8 p.m. (beginning Tuesday, December 5th) by the Rev. J. H. Greig, Vicar of St. Paul's, Lorrimore Square, S.E.

The Confirmation Class for ward and other maids will begin on Thursday, December 7th, at 8.15 p.m.

During Advent there will be a celebration of the Holy Communion on Thursdays at 8.40 a.m., in addition to the 7 a.m. celebration.

Papers by Guy's Men.

Further Experiments with Pane's Antipneumococcus Serum. By J. W. H. Eyre, M.D., and J. W. Washbourn, M.D.—*British Medical Journal*, 4th November.

Some Cases of Abdominal Injury. By A. W. Sheen, M.S., M.D., F.R.C.S.—*Clinical Journal*, 8th November.

With Mr. Symonds in the Wards of Guy's Hospital.—*Ibid*, 15th November.

Passim.

We understand that it has now been definitely decided by the House Committee to appoint a Resident House-Surgeon for the Eye wards. The tenure of his office we do not yet know, but we should imagine it would be somewhat shorter than that of the ordinary House-Surgeon in the Surgical wards. The step is one in the right direction, however, for it was somewhat anomalous that two such comparatively large wards as Barnabas and Ruth should be managed under a different system to the rest of the hospital. There is plenty to learn in the Eye wards, and the appointment, besides being a distinct advance in the management of the wards, should be a popular one.

The Smoking Concert on November 18th was a huge success, and belied all the forecasts of the croakers. Objection was taken by some to the price of 2s. charged for admission, but it was evident to those who knew anything of the present scarcity of genius at the hospital that it was impossible to run a concert with purely local talent. Hence the presence of professional artists and a charge for entrance. The great success of the evening fully justified the Residents in their new policy, and the general verdict was that we had just listened to one of the best smoking concerts of recent years. To two gentlemen especially is the credit due: to Mr. E. W. S. Rowland, the President of the Residents, and to Mr. A. A. Miller, who was largely instrumental in bringing to the concert such excellent performers.

Financially the concert did exceedingly well. After all expenses had been paid there remained the substantial balance of £9 13s., which will be given to the most needful of the Christmas funds. Also to record the inevitable at this season, the "Absent Minded Beggar" was recited, and between £6 and £7 was collected and handed over to the *Daily Mail* War Fund.

While speaking of funds, it may be worth while to say a few words concerning Christmas ward funds. The annual eruption of little collecting books has occurred, and it is imperative upon all, from Residents to dissecting-room men to help by contributions. To make the Christmas-tide festivities in the wards entirely successful much money is needed, and it is manifestly unfair that the Sisters of the wards should bear the greater part of the expense which is necessary for the entire enjoyment of everybody. "So pass the——," but quotation is unnecessary, and space can be saved.

Owing to many unavoidable delays we are somewhat later in issuing a Gazette Christmas card this year. Nevertheless, one is going to be issued, and will be ready during the early part of this week. It is by a well-known black and white artist, and depicts one part of the hospital which is above all others characteristic, viz., the colonnade steps. Samples will be on view in the library, and will be sent on application to all who live away from the hospital. The price will be the same as usual, 3d. each or 2s. 6d. the dozen, with envelopes. One important thing we would urge upon all men: that they would order cards early, and not delay till two days before Christmas, or they will be disappointed.

We regret to record the death of Dr. Henry Hicks, which occurred at Hendon on November 18th last. Dr. Hicks was a Guy's man, and qualified from this hospital in 1862. Always a keen geologist, in later life he devoted much of his time to that subject, and achieved great fame in the geological world, being elected President of the Geological Society in 1898. Only as recently as the opening meeting of the Physical Society, in October, was a tribute paid to his services to geology by a fellow-geologist and Guy's man, Dr. Wheelton Hind.

At this time last year it was announced from quite unknown and unreliable sources that decorations would not be allowed this year in the wards which had been newly done up—that is to say, Cornelius, Dorcas, Lydia and Queen Victoria. This is not the case. Provision has been made in the process of renovation for hooks at regular intervals along the walls, from which wires can be stretched, and the historic decorations can continue. It is requested, however, that random and unnecessary nails shall not be driven into new and expensive plaster-surfaced walls.

The results of the M.B. London and Final Fellowship Examination come this month as a curious contrast. In the M.B. nine out of twelve candidates passed, or seventy-five per cent., whereas in the Fellowship almost the reverse occurred, four candidates out of five being ploughed, or eighty per cent.

The Fellowship results are the more disappointing, as especial trouble had been taken this year to make the new classes for this examination a success, while for the M.B. no classes of any sort were held. It is, of course, quite unfair to contrast the two examinations in point of standard, but it is very hard that such a great deal of trouble should have been taken for the Fellowship for such a poor result.

The first paper of the Season was read before the Physical Society on Saturday evening last. Mr. G. S. Simpson was announced to read a paper on "Infusion and Transfusion," but to the surprise of many the paper was eventually read by Dr. A. P. Beddard. The reason of this was that Mr. Simpson supposed his time was coming later in the season, and Front Surgery duties gave him no time to complete his paper so early, consequently to avoid disappointment Dr. Beddard wrote his excellent paper at very short notice. The meeting was most successful, and the paper will be published in the next issue of the Gazette.

On Thursday, November 9th, Mr. W. S. Handley was presented by the Dental Students with a gold cigarette case engraved with the Hospital crest and an inscription in recognition of his services as coach for the L.D.S. examination.

The Bradshaw lecture at the Royal College of Surgeons on December 13th will possess an unusual interest for Guy's men. The lecture is to be "A Centennial Review of Surgery," and will be delivered by our senior surgeon, Mr. H. G. Howse, than whom, from his wide experience, none is more qualified to speak. Fellows and Members of the College will be admitted free, and students may obtain admission on the presentation of their private visiting cards. A large number of Guy's men should be present to give Mr. Howse a worthy reception.

The Debating Society holds its second meeting this evening. The subject of the debate will be:—"That in the opinion of the House the present social state of England is in urgent need of reform." Mr. H. Wacher will propose the motion, and Mr. G. Kitchen will oppose. The subject is hardly as debatable as politics, but the Debating Society is so full of life this year that the evening cannot fail to be entertaining. To one thing speakers might pay some regard—the value of fluent brevity.

Up to the present there has been no more news from Mr. Fremantle, at the Cape or Durban, wherever he may be. Lieutenant Onraët, R.A.M.C., is up with the fighting line somewhere, and Surgeon Beadnell, R.N., whose landing from the *Powerful* we chronicled in our last number, is now shut up in Ladysmith. From all accounts the surgeons will have their hands full.

The match against the Old Merchant Taylors on the 25th ult. produced a good game, which ended, unfortunately, in a defeat for the Hospital. We were without the services of Jackson, Cutler, Thomas, and Manson, and the forwards, overweighted as they were, did well to prevent a larger score. Their tackling was keen and decisive, and their rushes occasionally good, but they were slow in getting the ball in the scrum, and more than once, when it should have been heeled out, it was deftly returned into the pack by some misguided person in the back rank. Jupp was fairly good at back, though suffering from marked nervousness. Sime, recovered from his Cardiff injury, played really well, and was unlucky in not scoring. We regret to say that there was too much talking behind the scrimmage, and would point out that instructions and criticisms during a game should come from the captain.

The hospital continues to be represented on Saturdays by from six to seven football teams, four Rugby, and usually three Association. This speaks well for the keenness of the respective captains, as it must be a heartrending business for the captain of a fourth fifteen to reorganise a team decimated by untimely Saturday scratching. The 11th was notably an all round successful day, as six teams won their games and the seventh drew. On the following Saturday three of the four Rugby teams again won. The Rugby fifteen has been unlucky this season in not having played two consecutive matches with the same team. It is to be hoped that the various injuries are in a state of resolution, and that the team will get together after Christmas.

The present number of the Gazette is more sober-minded than usual. Owing to a great press of matter it has been necessary this week to curtail all flippancies, and "In Lighter Vein"

and "Nursing Notes" have been reluctantly excluded. Their cessation is, however, only temporary, and next number will not be of such a solid character.

Case for Diagnosis.

E. T., 31 (female), was admitted to Miriam, October 6th, 1899, for bleeding from the anus. She began to pass blood per anum twelve months ago, and continued to do so for four months. The blood was bright, and generally in clots, and was not intimately mixed with the motions. For last eight months bleeding has been intermittent, and once or twice has been severe. On keeping in bed for two months the bleeding diminished, but increased as soon as she got up. She has never been free from hæmorrhage for as long as a fortnight. There has been but little diarrhœa. After hæmorrhage, breathlessness and precordial pain was marked. Temperature, 100·2°; pulse, 80; respiration, 14.

Patient is pale and anæmic; there is marked œdema of both legs. There is epigastric pain, and headaches are frequent. No abdominal tumour could be felt, but there was a bruit in epigastric region. By rectum the right ovary was somewhat enlarged and tender. There was marked tenesmus.

Circulatory System.—A systolic bruit was audible over whole præcordia; it was soft and blowing.

Urine.—Sp. gr. 1016. Neutral—no albumen or sugar.

By October 12th, the œdema had disappeared. The hæmorrhage from anus continued, especially when the bowels had been opened, but not when confined.

(*For solution see page 520*).

Appointments.

CIVIL.

Meachen, G. N., M.B. Lond., M.R.C.S., L.R.C.P., has been appointed House-Surgeon to the Tottenham Hospital, N.

NAVAL AND MILITARY.

Staff-Surgeon W. J. Maillard, V.C., M.D., has been appointed to the *Dædalus* (temporary), and Surgeon J. G. Watt to the *Sanspareil*. Surgeon C. Marsh Beadnell, of the *Powerful*, is now with the Naval Brigade at Ladysmith.

Lieutenant H. P. W. Barrow, R.A.M.C., has been ordered to South Africa.

Dr. Owen Wynne Griffith, has been elected Mayor of Pwllheli.

NOTICE TO CORRESPONDENTS.

The Editor wishes it to be understood that no communications can be inserted which are not guaranteed by the name of the sender. All articles must be written on one side of the paper only.

"Religio Medici."

By Canon Taylor.

Monday, November 13th, 1899.

An Address to medical men usually includes, if it does not begin with, some very sonorous compliments to the profession. A clergyman once described it in my hearing as "by far the noblest of all professions." I could not help wondering why he had not devoted himself to it. *I* think that mine is the noblest of all professions. For that reason it is also the most awful and degrading of mockeries, if the man who exercises it is not honest and earnest. "*Corruptio optimi pessima.*"

But conceding to one another that each of these ministries, the medical and the spiritual (for both are such) is the best for ourselves respectively, it is plain that we may have in each a higher or a lower ideal, and each will have its charactistic difficulties and temptations accordingly. May I touch on one ideal, corresponding to which is a temptation which belongs both to your work and mine in different ways? Our ministries should be reverent; and we are tempted to fall short of that ideal.

It is possible to look out on the world with a cool, pert business-like eye, to measure in a fashion its substance and forces, and to see nothing impressive, no mystery, anywhere. And it is possible to look on it with a growing wonder, lifted out of self, searching reverently for a meaning and an end behind its vastness and variety.

You remember the child's story of the giant's daughter, who found one day what was compared with herself a little pigmy man, ploughing his fields, and brought him home in her apron gleefully to set him on the table before her father as a toy. And how he told her that this was a living creature, with thought and feeling, with perhaps a pigmy wife and children very dear to him, and not to be used as a plaything, but to be treated with consideration and kindness and respect. Familiarity may reduce the size of things to us. We may from the multitude of them, from the frequency of our contact with others, lose our reverence. They may become mere toys and pieces on the board, to be dealt with in certain cut and dried ways, and according to certain rules of practice. Then, doctor or pastor, we have lost our first touch, for souls as for bodies.

We need to remember what all real thinkers recognise, whatever the sphere of their thought, that all we know shades off into mystery—the unknown or the unknowable. That even the simplest fact is not to be dismissed summarily, but has aspects which transcend the highest human knowledge, so that to know it in the fullest sense, exactly its place and meaning in the universe, would be to know the universe itself.

"Flower in the crannied wall,
I pluck you out of the crannies,
I hold you here, root and all, in my hand,
Little flower, but *if* I could understand
What you are, root and all, and all in all,
I should know what God and man is."

How much more those infinitely complicated bundles of phenomena, the human body and mind?

But your danger is lest you should grow to think of a man as an arrangement of bones, muscles, nerves, and so on, with which are associated certain phenomena we know as mental sensation, emotion, intellect, volition—a mere elaborate machine, answering to certain known impulses in certain ways, and subject to a catastrophe of dissolution called death—and nothing more.

But you have not exhausted the circumstances so. And you must take in all the facts if you are to grasp and master the case. In a sense it is difficult, because by the nature of your profession you must specialise. It is enough, however, if you make room in your conception of human nature for other undeniable realities than those which fall under your immediate professional interest.

And here is one, unquestionably great and serious, that man, so like other animals in many respects, is unlike them in this: he is a religious animal, and the only one. That is not only a fact, which I need not labour to prove to you (enough to say that it has changed the course of the history of the world again and again), but it is a fact not less but greater than any of physics or chemistry, though we may not be able ourselves to understand it. You must take it into consideration. You must find a place for it in your scheme of thought, though it be on a different plane of things from that with which natural science is concerned.

A reverend mind will stand patiently before all the facts, explicable or not, of morals, of conscience, of tendencies to worship, of belief in the supernatural. These are not to be forgotten, to be put aside as of no moment, to be ignored. They have affected millions of our race with the most pathetic hopes and fears, the deepest desires and aspirations, living and dying. They are of greater moment (though all knowledge is of moment) than even the knowledge that produced photography or the use of the Röntgen rays. "One can," our Poet Laureate says, "in case of necessity dispense with tramways and telephones, but we cannot dispense with right thinking and right feeling." A thought which Pascal put in another way—"The science of exterior things will not console me for ignorance of the moral in the time of affliction."

We need reference for facts, and especially—for they will be most in danger of being ignored—reverence for religious facts: sin, temptation, repentance, conversion, grace.

Reverence for human nature will follow if we take in all the facts.

I remember being struck some time since, with the forceful way in which Sir Russell Reynolds brought out this point in an address to medical students. "The mysterious material body which in your case must be regarded as but a subservient part of a more mysterious whole, and you must never forget the higher elements in your eagerness to understand the lower." And again—"As physicians and surgeons it is our part to conserve life by preventing, when we can, the inroad of disturbing agencies, to preserve life in its integrity of useful work and fit association with all that makes life happy; to help it in its weakness, heal its suffering, lessen its sorrow, and soothe its closing hours; but I think we shall accomplish these purposes only by admitting its existence, its separateness from all other forces, acknowledging its mystery, bowing ourselves down before the enigma of its origin, and reverently humbling ourselves in face of its unsearchable but wonder-teeming end."

It is there that the parish priest and the medical man shake hands, in constant association with the same cases, in constant points of meeting. And their connection should be a mutually encouraging and helpful one. I can speak from knowledge on that, for as Vicar for some years of a large thickly-populated parish in the north of England, it was my happy experience to find in the doctors of the neighbourhood, not merely gentlemanly acquaintances, but friends. And my experiences were the more interesting, as they were concerned with men of very different points of view in religious matters. I run no risk of being over-personal in speaking of them; various circumstances have moved us all from the spot.

One was a man that may be frankly described (though it is not well to ticket people, and some cannot be ticketed) as a high churchman, with a big body, and a kind heart. His interest was great in matters of ecclesiology—church architecture, ceremonial, etc., all fascinated him. He was none the less keen in his own profession for that. But I knew that he had a keen eye on my ritual, and probably thought it sadly behindhand. I felt that he had a watchful scent for the orthodoxy of my sermons. Often at the early communion on Sundays, and at evensong he did not approve the method of a hasty call out from church, and so reserved the morning for patients. How I remember one dark afternoon when his little boy, whom in his heart he had destined for holy orders, was suddenly killed by the kick of a horse, sitting with him as he bore his grief like a Christian man, but saying nothing—like Job's friends (in their wisest mood) for "his grief was very great."

Another, to whom (by chance, as we shortsightedly say) it happened that in the only serious illness of my life I was indebted for the most devoted care, was, by his confession, agnostic. A bright, hearty, loveable man, with, alas, no great opinion of parsons. It was one of the superstitions of his life that I was different from the rest, and he would indulge in rosy pictures of what might follow if others could be brought into line. There was no assertion in his unbelief. He did not "profess" it; and seldom referred to it other than indirectly. He was never scornful of the convictions of others. And no one would send to me more carefully when a sick person needed the comfort of prayer or the last Sacrament, or when he thought that a careless liver might be the better for a visit in an impressionable mood. He is hundreds of miles away now, and for all I know his intellectual difficulties are still as great. But he is "not far from the Kingdom," and one day, here or hereafter,

I believe that God will lead him in, as in the infinite resourcefulness of His love He knows best.

I weary you, perhaps, but I cannot leave out another, a Low Churchman, who perhaps thought (he never told me so, and his friends wondered at it) me dangerously "sacerdotal," but wet or fine, there he was in his place in church, and on very great days at the Sacrament. And the scale of his giving to the church's work and charities, as I happened to learn indirectly, was of a singularly generous sort, though he was never anything approaching to a wealthy man. He was an old Guy's man, getting really old now, but when he came to see me last summer and left late in the evening, it was a bit touching to see him go from my door to walk just to and fro once more in front of Guy's—that was bound up with so many memories of the long past.

There was in these men, differing in their religious standpoint so considerably, a uniting bond of likeness—they were each at bottom of a truly reverend mind. So their profession was not a mercenary affair to them, and their patients not valued, above all other considerations, at so much current coin of the realm.

And all reverence, whatever shape and direction it takes, all recognition of the mystery that lies behind nature, and especially human nature, is, consciously or unconsciously, reverence for God. Happy are those with whom it is fully conscious, who place themselves in the hands of the Almighty Father of all, to be the workers out of His purpose, His loving kindness, to our suffering brethren. Then a full view of every case will be taken, the doctor will care for the moral and spiritual state of the patient, as the true parish priest must care also for the physical condition of the sick.

So it was with Sir Thomas Browne, the prosperous Norwich physician, whose book (which has given the title for the course of addresses to which this, I fear, is an unworthy prelude), the "Religio Medici," should be on the bookshelf—it will not take much room—of every medical man. So shrewd, and quaint, and devout. "I never heard the toll of the passing bell," he said, "without my prayers and best wishes for the departing spirit. I cannot go to cure the body of my patient, but I forget my profession, and call unto God for his soul." That was an amiable forgetfulness surely. It arose because though he had a wholesome grasp of the material side of things, he had also a constant apprehension of the divine in nature and in man. He showed it in the reverence of his outward gesture and bearing. "At my devotions I love to use the civility of my knee, my hat, and hand, with all those outward and sensible motions which may express or promote my inward devotion . . . At the sight of a cross or crucifix I can dispense with my hat, but scarce with the thought or memory of my Saviour."

The outward with him reflected the inward reverence. "There is surely a piece of divinity in us, something that was before the elements, and owes no homage unto the sun." And his view of the past made him say: "Now for my life it is a miracle of thirty years, which to relate were not a history, but a piece of poetry, and would sound to common ears like a fable."

With anything approaching to the full and reverent view of life there will come to you again and again the opportunity and, I trust, the impulse to remonstrate, to warn, to turn the mind of a patient away from the baser and towards the better things. But your advice in that region will not ring true unless the standard of your own lives is at least seriously aimed at that which you urge and recommend.

In the old allegory, so little read nowadays, of Bunyan's "Pilgrim's Progress," there occurs the incident of Matthew, Christian's son, eating of the fruit of Beelzebub's orchard (as many a Christian's son is doing to-day), and how Mr. Skill the physician is called in, and after vainly trying some other remedy, effects a cure by medicine made *ex carne et sanguine Christi*. [Good honest Bunyan, who was a brazier by calling, and his education of that sort, put in the margin of the first edition, I am told, "the Latin I borrowed."] It was to be taken fasting and with a certain measure of tears of repentance, and was good to prevent diseases, as well as to cure when one is sick.

If the "Mr. Skill" of to-day is to prescribe such medicines at times, as I hope you may find your opportunity of doing—for so is it that we are of greatest service to the wayward, sinful, weary, passion-tossed heart of man or woman—remember, this is a prescription which must come from one who has tried it himself, from one who knows.

The next lecture will be delivered by Mr. George Russell on Monday, December 11th, at 5 p.m. Subject of lecture, "Influence."

Pass List.

University of London, October, 1899.

M.B. Examination.

First Division.—H. L. Eason, C. T. Hilton.

Second Division.—E. S. Hall, G. N. Meachen, A. G. Osborn, H. M. Reeve, J. Robertson, W. G. Stewart, P. Turner.

Royal College of Surgeons of England, November, 1899.

L.D.S. Examination.

J. S. Biss, J. Black, C. H. Bubb, H. T. Campkin, P. P. Cole, G. H. Drake, F. W. Garman, S. H. Jones, W. W. C. Jones, S. H. Longhurst, H. Maurice, R. J. Morrell, J. B. Morrish, S. L. Pallant, R. Peacock, F. J. Pearce, G. P. Pollitt, C. F. Rose, A. H. Saunders, W. H. Tattersfield, S. J. St. H. Tweney, J. H. Wilkes.

Guy's Hospital Dental Society.

A MEETING of this Society took place on October 10th, at 5 p.m., and was attended by thirty-eight members The President, Mr. A. E. Baker, opened the proceedings with the customary address—

GENTLEMEN,—In addressing you on this, the first occasion of my occupying the presidential chair of the Guy's Hospital Dental Society, let me first of all thank you most sincerely for the honour conferred upon me by my election to so important an office. It is one which affords me not only very great pleasure in filling, but also a certain amount of apprehension. The pleasurable part will consist in my being able, as I hope, in some small measure, to forward, with your assistance, the aims and objects of our society, which none can say are not worthy of members of a great metropolitan school of medicine, surgery and dental surgery. The apprehension arises from contemplating the very able manner in which your former presidents have hitherto presided over your discussions and stimulated your energies towards the attainment of further scientific knowledge, and of these none has been more deserving of our full meed of praise than our retiring president, Mr. M. F. Hopson. His untiring zeal in the promotion of all that is healthy and right in a professional sense, and his admirable eloquence in expressing his views, proclaim him to be not only the first man trained in our school, but a typical Guy's dental man. You will find, I am afraid, that my humble efforts will be of a more mediocre description, yet I can assure you it is my earnest wish and endeavour to make for progress in our society. "Excelsior" has been the motto of the 19th—it will be even more so that of the coming 20th century. The whole world is not only being carried onwards by the march of improvement, but hastens along of its own free will. We, too, must in no sense lag behind, and indeed, knowing so many of you as I do, and how exceedingly interesting the profession of dental surgery becomes to its true disciples, I do not fear any "marking time" on our parts. But before I say more, let me, in the name of the Guy's Hospital Dental Society, offer a very hearty welcome to the recruits who have lately joined our ranks. We hope to have the names of all the men of the new entry enrolled on our list of membership, and that they will assist materially towards the success of our meetings by contributing papers, objects of scientific interest, and by joining in the discussions. On reference to the "Rules and Objects" of this society, I see that the latter are "The consideration of matters generally and specially appertaining to dental science." Let us, therefore, examine very briefly one or two directions in which we may hope to attain progress not only in dental science, but in that science applied in a practical form. Anyone who has operated for a number of years cannot have failed to note in how many details there is a vast room for improvement. I enumerate a few which have often occurred to my mind, in the hope that many here present may think over them with a view to our future benefit. Let me first of all appeal to the gentlemen amongst you who are skilled in amateur photography to form a small sub-committee amongst yourselves with the object of procuring, both for the practical work of the conservation room and for the museum, a large series of radiographs showing the teeth with the roots *in situ;* but what I should like to see more than the actual radiographs themselves is a small number of you capable of, and willing to take these as required. It would be a great help to the members of the staff if we could be absolutely certain, when cases for the regulation or crowning of teeth present themselves, as to whether buried or unerupted teeth are present or not, or whether roots are normal, in good position, or long enough for the various crowning and regulating operations; in fractures of the mandible, whether the fragments are in juxtaposition. In the Electrical Department the methods of obtaining good radiographs of the teeth are imperfectly understood, and probably they have quite enough demands upon their time from the general wards. For this reason, and especially as we are this session blessed with an electric supply, it would be as well if we could have our own apparatus, under the care of the sub-committee aforesaid. Should such a committee be formed, I expect that the Dental Council (but I do not speak officially, not being a member) would supply us with the necessary instruments. Another point which needs elucidation, and towards which I would direct your attention with a view to collecting statistics and other data, is the frequency with which one finds shrinkage of the gum preceded by absorption of the alveoli in mouths of otherwise apparently healthy people. I do not mean that shrinkage and absorption which accompany pyorrhœa alveolaris, or other manifest cases of abnormal conditions of the gums, but that in strong, well-nourished people, where the gum itself presents all the characteristics of the normal tissue. Of late years, I have noticed a great increase of this condition in my private patients, and am not clear in my own mind as to the initial or continuous influence producing it. By some observers it is ascribed to rheumatism, by others to gout, early syphilis, smoking, etc., etc., but it is not definitely known as to whether it is due to any one singly, or to a combination of these possible causes. The shrinkage is apparently as common in females as in males, and noting how many teeth get loose and have to be extracted from this cause alone, it would be to our advantage if statistics of hospital patients can be procured, with a view to throwing further light on this little known subject. There is also room for much investigation as regards the abnormal conditions of the gum and mucoperiosteum of the mouth, and in spite of the splendid work done in bacteriological research by our colleagues, Dr. Washbourn, Mr. Kenneth Goadby and others, there is a vast amount of work yet to be undertaken, and in which medical and dental scientists can work side by side, and by mutual assistance unfold more of the truth of many processes, which as yet we have not grasped.

To me it has often seemed a lamentable fact that, in spite of our present skill in arresting caries, restoring the functions of individual teeth, and in providing artificial substitutes, we are in most instances simply treating effects, and are unable to attack the causes from the very commencement. Much can be done by teaching the habits of cleanliness, and the use of antiseptic mouth-washes and dentifrices, to reduce the potency of the causes, but we are not yet able to promise any one of our patients complete immunity from dental loss or suffering, and this, I take it, should be one of the chief aims of our practice, even if it be somewhat idealistic. The mention of dental suffering brings me to the need which we have of local anæsthesia. The age in which we live seems to be a highly nervous one, there is no doubt that we as a generation are more sensitive and feel pain more acutely than our forefathers are supposed to have done. The teeth of children seem to decay more rapidly, and the difficulty of manipulation is immensely increased by the exquisitely sensitive nature of the denture to be operated on, and heightened by the intense dread which is characteristic of the highly nervous patient. My own practice obliges me to operate upon many very youthful patients, and often I would give a great deal to be able to anæsthetise the main trunks of the dental nerves supplying given portions of either the maxilla or the mandible for a limited period, so as to enable us to do a theorectically correct filling in an absolutely painless manner, and yet in such a way as to lead to no bad after-effects. This may seem a very ideal procedure, yet I venture to think it is one which a society such as ours may well take to heart, and one again in which our medical confrères could co-operate with us towards its attainment. Again, I would commend to your notice, gentlemen, the claims of our teaching museum which is under the able supervision of one of our vice-presidents, Mr. Lewin Payne, who invites us to supply him with serial models of different regulation cases, cleft palate cases, pathological specimens, abnormalities and objects of interest of all descriptions. And as an adjunct and sub-section of the museum, I invite those of you having a "penchant" for dental microscopic work to assist us in getting together a number of sections of teeth and jaws of a great many of the natural orders dealt with in your dental anatomy course. We wish to obtain both hard and decalcified sections of numerous fish, reptiles and mammals, both small and great, over and above those we are able to deal with in the limited time devoted to the class work of the summer session. Gentlemen, I might mention many other subjects with a view to arousing your enthusiasm for dental science, but time is getting on, so let us be content with having enumerated these few, and may we hope to hear your views more fully expressed upon them at our future meetings. In looking at the world around us, none of us can fail to be struck with the fact that during the last four or five years, the idea which has so to say "caught on" the most, and that is gradually becoming a well accomplished fact is that summed up in the word "Imperialism." Never have the mother country and her colonies and dependencies been drawn so closely together by the strong ties of blood and affection as at the present time. I think, too, that we members of the Guy's Hospital Dental Society can perform our part in cementing and strengthening this beneficent "union of hearts." Let us determine that, by our enthusiasm and zeal in the cause of dental science, Guy's Hospital shall be such a centre of dental learning, and such an exponent of dental practice, as she is already in medicine and surgery. So let our light shine forth and attract to us many from all parts of the British Empire, and let our teaching and practice be such that our graduates may always look back with pleasure on the time of their sojourn within our gates. This thought was borne in upon me more than five years ago, when visiting the United States. There I saw men from our Australian Colonies, from the Cape, New Zealand, etc., who were going through the curriculum for the D.D.S. degree. I was of opinion then, and still believe, that we ought to be able to attract such men—our colonial cousins and citizens of our Empire—to the metropolis of that Empire, and when they have reached this city we ought to have many of them at Guy's. Nor do I fear the prospect of our numbers rapidly increasing. In one city (Philadelphia) of the U.S.A. I was shown over three large dental colleges, two of which had over 300 dental students each, and the third had about 250. So it seems to me that if Philadelphia, with a population of a little over one million, can support three large dental colleges of this nature, the three dental schools of London, with its five or six million of inhabitants, ought not to be at any lack of teaching material, nor should Guy's be content to take any but the first place. In conclusion, gentlemen, let me thank you for your patient attention, and hope that with the kindly assistance of our Secretary and Treasurer, with that of the other members of the Executive, my year of office may be a satisfactory one for all of us.

The Secretary then presented the balance-sheet together with the minutes of the last ordinary meeting, and these having been passed, two letters were discussed: the first was from Dr. Silk, who placed himself at the disposal of the society owing to his having severed his official connection with the dental school; and the second was from Mr. Wilkes, who stated that he was no longer eligible for the committee. With regard to the former, the president put it to the meeting that, considering Dr. Silk's old and valuable association with the hospital, it would at least be complimentary to ask him to retain his vice-presidency for the remainder of the academical year. The meeting expressed regret at Dr. Silk's separation from the hospital and unanimously passed the president's proposal. Re the second letter, the president said another representative must be elected *vice* Mr. Wilkes, resigned; he also drew the attention of the meeting to the fact that the number of members on the committee did not coincide with their regulations, and therefore at the next meeting two representatives

of students in their second year would be elected. The president then called for the "casual communications."

Mr. BENNETT showed a case of "open bite," which proved singularly interesting. Various theories as to the cause were put forward, amongst them being Mr. Dowsett's osteo-arthritis of the temporo-maxillary articulation. The president suggested that a radiograph might prove of great service.

Mr. STWENI showed some specimens exhibiting exostosis, abnormal number of roots, and retained unabsorbed temporary tooth.

Mr. HICKS showed a model of cleft palate from premaxilla to naso-pharynx.

Mr. WALKINGTON showed a good example of geminated upper central incisors, and in the same mouth the upper left lateral had never erupted. The president recalled a somewhat similar case in his experience, and a discussion occurred in which several gentlemen took part.

Mr. SEARLE was next called on for his paper on "A few considerations on Gold Fillings," and at the conclusion answered various interrogations, and received the thanks of the meeting.

The president next published the date and subject of the paper for the next meeting and was cordially thanked by Mr. Rowlett for so kindly taking the chair, and this closed the proceedings at 6.30 p.m.

The Lessons of the Direct Representatives' Meeting at Newcastle.

IT is to be hoped that every member, or prospective member, of our profession will read, mark, learn and inwardly digest the published reports of the speeches and discussion at this conference on November 22nd.

Tied and bound as medical men are, scarce knowing the meaning of leisure, this meeting of nearly 200 from all parts of the counties of Northumberland and Durham, as well as representatives from Manchester and Yorkshire, must be considered a milestone on the road to medical reform. Time unfortunately—though the proceedings lasted five hours—did not serve for certain resolutions dealing with medical organisation to be brought forward at all.

As any real and progressive reform is impossible without united action all over the kingdom, it will be seen that the first essential for this must be a much more perfect organisation than has so far been put into action.

One of the postponed resolutions runs:—"That it behoves all medical practitioners to become members of medical unions, or societies, or guilds, in towns and counties throughout the United Kingdom; in order to secure a proper representation of the profession on the General Medical Council."

By himself, each practitioner is an isolated unit, an unenfranchised helot, rooted to the soil. Individual grumbling as to the imperfect way in which our professional privileges, not to say rights, are protected by the Act of 1858, which was intended to secure them once and for all, and by the General Medical Council, constituted by that Act, is utterly useless.

Nothing will be effected by these inarticulate mutterings in a practical sense until every medical man makes up his mind to join his branch of the British Medical Association, or a local union, or a guild, or all three, and to attend every meeting he possibly can, and do his utmost to push medical politics into the front. Licentiates and members of the various corporations which have qualifying powers must band themselves together and hammer, *hammer*, HAMMER, at their respective councils until the door of the franchise is open to them. Graduates of Universities must become members of their respective convocations, and keep on with resolution and tireless perseverance until an adequate voice in the election of their representatives is as a matter of equity accorded to them.

Every means must, too, be sought to keep the Council of the British Medical Association awake and up to date, as well as the Parliamentary Bills Committee of the same. Strongly worded resolutions insisting on reform must be fired on to the General Medical Council from all the positions indicated above, and the volleys must be continuous and general. Reform of the General Medical Council, apart from the way in which the corporate and University representatives are elected, must be pressed on the Council itself by Parliamentary aid, if it cannot be forced to exercise the powers conferred by previous Acts.

Every medical man should make himself familiar with the grievances which are general and widely spread, and seek to gain the attention of his own Parliamentary representative to his own view of them.

Amongst such subjects may be enumerated:—

Death certification.
Registration of still-births.
Unqualified practice, and midwives and opticians.
Contract practice.
Medical associations run wholly by the laity.
Hospital abuse.
Re-vaccination.
Vaccination in one place only.
Tranference of the appointment of vaccination officers to the local sanitary authority instead of the Poor Law Guardians.
Increased direct representation on the G. M. Council, and reform in its procedure, especially in penal cases, where it should have the power to take evidence on oath.

It is to be hoped that the Conference which is being arranged for the first week in May, at Manchester, will prove another milestone on this long and winding road.

A. J. SHARP.

Whitby, Yorks.

Nursing News.

Matron's Office.

Miss Lydia Hardiment, who trained here for three years and then joined the Army Nursing Service, has been appointed Superintending Sister of the base hospital No. 2.

Miss Clara Chadwick, who trained here for one year and afterwards joined the Army Nursing Service, has been appointed Superintending Sister of the "Princess of Wales" Hospital Ship.

The following information has been obtained from *The Hospital*.—

A Guy's Nurse in charge of Harrismith Hospital.

Miss Margaret McKechnie, who is now head of the nursing staff at Harrismith, was trained at Guy's. The authorities of the Free State practically "commandeered" her, and though, being an Englishwoman, she naturally objected to have to work, as it were, for the other side, she accepted the position without protest, believing that the hospital would be in charge of Dr. Wilson, whom she knows well and who is much liked. This was also the expectation of Dr. Wilson himself, or he would have left the town while he could; but owing to the fact that he is a fine shot and a good rider, he has been ordered to fight against the English. Miss McKechnie is a native of Harrismith, where her mother and two brothers reside. One of the latter holds an office under the Free State Government, and will remain near his sister. The other has been sent with Dr. Wilson to the front. Miss McKechnie writes that her poor mother is almost broken-hearted that those amongst whom they have lived for years as friends should show so little consideration for them as to make one of her sons take arms against his own countrymen.

For the information of the Nursing Staff we give the following, reprinted from the "Regulations for the Army Nursing Service Reserve":—

1. The Army Nursing Reserve is formed for the purpose of supplementing the regular nursing service of the Army in the event of war on any extended scale. In time of peace, it is under the control of a specially constituted committee, of which Her Royal Highness, Princess Christian of Schleswig-Holstein is President; but in time of war, the Nursing Sisters (or as many of them as may be required), will be entirely under the control of the War Department.

2. The Army Nursing Reserve will consist of 100 or more Nursing Sisters,* a certain number of whom may be detailed by the military authorities as Acting Superintendents.

* Although, as a rule, the Sisters are only expected to replace in military hospitals at home those members of the Regular Army Nursing Service ordered abroad, nevertheless in case of pressing emergency, a certain proportion (selected from volunteers) may be called upon to proceed on service at short notice.

The Smoking Concert.

The best Smoking Concert of recent years took place on Saturday, November 18th, in the College Dining Hall. There was a very large attendance of men—close upon 150—and the hall was crowded to overflowing. Several members of the Staff, including Dr. Horrocks, Dr. Fawcett, Mr. C. B. Smith, and others, were present. As there were not enough men at the hospital to make a full programme, outside aid had been resorted to in the persons of Messrs. Stanley Graham (an old favourite at Guy's), Wilson James and Mark Hyam. These three gentlemen were all in excellent form, and gave some of the best items on the programme, which was of great length, the concert lasting from half-past eight till past twelve.

Detailed criticism is unnecessary, especially at smoking concerts, where half the enjoyment depends upon the particular state of mind at the time being. Suffice it to say that the three above-named gentlemen sang some of the best songs we have heard for some time, and got enthusiastic receptions. Mr. Mark Hyam recited "Gunga Din," and while doing Kipling, had to yield for persistent demands for "The Absent-minded Beggar"—a recitation which resulted in boundless patriotic enthusiasm, and a cheque for £6 odd for the *Daily Mail* War Fund.

Mr. W. R. Cazenove ran up from Northampton for the occasion, and quite impromptu sang his now immortal song, "Neckinger Nora,' and dedicated it to Dr. Horrocks, who responded in a brief but humorous speech. The song belongs to the naturalistic school of compositions, and its directness of epithet forbids quotations. It will live, however, in the Charities' room for many years to come

Among singers of the sentimental variety, Messrs. Starling, Parrott, Atkins and Docwra—the last a newcomer—gave of their best, and Miller and Brockwell sang two excellent comic songs. Mr. Norman Blume gave an excellent mandoline solo in the first part of the programme, and later in the evening, with a friend, took part in a duet in the style of the late lamented two Macs.

A new star which has burst upon the firmament at Guy's is Mr. F. A. Segreda, who scored an instant and uproarious success with the haunting "A Frangesa," and as an encore, "Funicula, Funicula."

During the course of the evening many tried their hand at accompanying, the majority without apparent justification, but Mr. Taylor deserves especial praise for his continued and successful labours in that direction.

The audience was merry, exceedingly patriotic and cheerful, but never got out of hand, and the best thanks of the whole hospital are due to Mr. E. W. S. Rowland for an excellent programme and excellent concert, well managed and carried out. We can do a smoking concert here at Guy's after all.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Midwifery in General Practice.

DEAR SIR,—I am sending the following notes on the first hundred cases of midwifery I have attended this year, thinking they may be of interest, as there has been a good deal of controversy lately on the subject of artificial interference in labour in the medical press. I shall be glad to hear how other Guy's men act.

100 cases—Forceps used in 22
Turning „ 9
Normal „ 69

I use Porter-Matthew's axis traction forceps in preference to any others, and am able to apply all necessary traction with two fingers; making a practice of using the forceps when there has been no advance for two hours. I also use a Champetier de Ribes' bag in all cases where the membranes have prematurely ruptured.

Many of your readers may think my average of turning cases is high, but I hold that if occipito-posterior presentations fairly high up will not rotate and fail to advance it is fairer to turn than to apply forceps.

IN conclusion, I will quote an unusual average of twin births. From August 9th to November 4th, out of thirty-three cases attended, five were twin births. The presentations were as follows:—

1. Caput and caput.
2. Caput and breech.
3. Caput and breech.
4. Breech and caput.
5. Caput and caput.

These were all delivered naturally.—Yours truly,

A. Z. C. CRESSY.

Wallington, Nov. 19th, 1899.

Sport.

Rugby Football.

GUY'S v. BEDFORD.

(GUY'S, 19 POINTS; BEDFORD, 5 POINTS).

Saturday the 18th day of November, was hardly an ideal day for football, and at Bedford there was a fairly thick mist hanging over the ground when Mullins kicked off. Guy's were without Jackson, Sime, Cutler and Manson; and Bedford was hardly at full strength. From the very beginning of the game, Guy's held the upper hand, but it was not until twenty minutes had passed that they were able to open their score, and then Walker charged down the opposing full-back's kick, and scored wide out, the kick being unsuccessful. The forwards were playing quite a good game, giving their backs plenty of opportunities, and it was not long before a loose rush took the ball close to the Bedford line, and Thomas giving a good pass, enabled Walker to get in in a favourable position, but the kick again failed. Guy's continued to hold the whip hand, and half-time arrived with no further scoring done.

After change of ends, the game for a time was very even, Morgan and O'Brien were conspicuous for good runs, and then Thomas, who throughout showed up prominently, scored in a favourable position, but yet again the kick failed. Almost immediately after the re-start, a scrum formed on the Bedford twenty-five line, and the ball was sent out to Pye-Smith, who eluded many opponents and scored close to the posts, and this time Louisson added the extra points. The Bedford three-quarters were then allowed to break through, and Udal scored wide out, but was allowed by the referee to take the ball up to the posts, and the try was majorised. The last item scored was a good try by Hicks for Guy's, who in the end won by 19 points to 5. Thompson and Thomas were the most conspicuous of our forwards, but the backs were hardly up to form. Team:—

GUY'S.—E. N. Jupp (back); E. Morgan, A. O'Brien, C. D. Pye-Smith, J. T. Hicks (three-quarter backs); M. Louisson, F. E. Walker (half-backs); R. C. Mullins, T. P. Thomas, A. H. Wall, R. Thompson, E. H. Milsom, K. V. Trubshaw, D. H. Trail, R. C. Lawry (forwards).

GUY'S v. OLD MERCHANT TAYLORS.

(OLD MERCHANT TAYLORS, 11 POINTS; GUY'S, 5 POINTS).

Mullins won the toss, and the Taylors kicked off; the return was not good, and play soon settled in our twenty-five. The Hospital forwards were rather over-weighted, and their opponents getting the ball smartly, gave them a warm time for a few minutes. O'Brien got in a good kick up the field, relieving the pressure, and Morgan by a dodgy run got into our opponents' quarters. Guy's were soon afterwards again on the defensive, and were compelled to touch down twice; half-time arriving with the ball in mid-field, and no advantage gained by either side.

Soon after resuming, the Guy's pack, which was now playing a much better game, rushed the ball down to the Taylors' line, and one or two scrummages were hotly contested in front of the posts; the home side, however, managed to work back to half-way. Sime then put in a good run on the left wing, finishing with a cross punt towards the posts, which he tried to follow up himself, but had the misfortune to be accidentally tripped up; Thompson, however, following up well, secured a try, which O'Brien improved by a good kick. The Merchant Taylors now made a determined attack, and their right wing scored at the corner flag, no goal resulting from the kick. They continued to press, and a series of scrummages took place right on our lines; the Hospital forwards packed and tackled well, but were unable to maintain their lead, as the Taylors scored again near the posts, and this time converted. Just on the call of time they again scored, but no goal was kicked. The

game resulting in a defeat for the Hospital by 1 goal, 2 tries to 1 goal; 11 points to 5. Team:—

Guy's.—E. N. Jupp (back); E. Morgan, A. O'Brien, C. D. Pye-Smith, F. W. Sime (three-quarter backs); M. Louisson, C. F. Watson-Smythe (half-backs): R. C. Mullins, D. H. Trail, A. H. Wall, K. V. Trubshaw, E. H. B, Milsom, R. C Lawry, H. S. French, A. R. Thompson (forwards).

GUY'S "A" v. BECKENHAM.

(Guy's, 14 points; Beckenham, nil).

Played at Beckenham on Saturday, November 18th. Guy's won the toss, and at once began to press, S. C. Brown opening the scoring with a neatly dropped goal fifteen minutes from the start; this was shortly followed by a try from Ring, and a little later Watson-Smythe, securing the ball, scored wide out, both kicks at goal failing. Ransford, who was playing three-quarter for Beckenham, was at this point unfortunately hurt, and had to leave the ground. In the second half Guy's had matters much their own way, but failed to score till S. C. Brown dropped another good goal at the call of time, Guy's thus winning by fourteen points to nil. There is still room for considerable improvement in the packing of the forwards, and they are inclined to leave the ball behind when wheeling. Allen at centre three-quarter is fast, but is inclined to be too independent of his wing man, and should learn to pass more often and more accurately. Harrison at back is steadily improving. D. P. Watson was the pick of the forwards. Team:—

Guy's.—M. Harrison (back); H. S. Brown, R. Wallace, H. N. Grose, C. A. E. Ring (three-quarter-backs); S. C. Brown, A. E. Kynaston (half-backs); D. P. Watson, E. J. Malim, C. A. Watson-Smythe, G. Mum, R. G. Anderson, H. McD. Parrott, F. Featherstone, M. A. Collins (forwards).

GUY'S "A" v. OLD MERCHANT TAYLORS "A".

(Guy's, 8 points; Old Merchant Taylors, 7 points.

Played at Honor Oak Park on Saturday, November 25th, and resulted in a win for Guy's by 2 goals (8 points) to 1 goal and 1 try (7 points). We were rather lucky to win, as we had to touch down seven times. Allen scored our try, Hicks converting; the latter also kicked a fine penalty goal for us at the end of the game. Both centre three-quarter backs seemed to forget the existence of a wingman. The halves had a bad time behind a scrum, who rarely got the ball, and when they did, generally let it out at the side, but they seem to be a little loth to pass. The forwards are rather slow at getting round behind the ball, and never seem to get the first shove; that they can get the ball when they like was shown by the last five minutes' play.

Guy's.—E. M. Harrison (back); J. T. Hicks, C. A. E. Ring, R. W. Allen, H. S. Brown (three-quarter backs); S. C. Brown, A. E. Kynaston (half-backs); E. G. Malim, T. P. Watson, R. G. Anderson, G. Nunn, H. Parrott, F. Featherstone, G. Watts, M. A. Collins (forwards).

Association Football.

GUY'S v. WEYBRIDGE.

(Guy's, 4 goals; Weybridge, 6 goals).

Played at Weybridge on Saturday, November 25th. Guy's lost the toss, but there was little advantage to be gained from choice of ends. The game was very even at the beginning. Guy's, however, managed to score the first point through Wiltshire. Ward, on the outside left for Weybridge, gave our back division no end of trouble throughout the game, being much faster than any man in the team. He got away soon after we scored and equalised. Points were then added for us by Barber and Norton. The score thus stood at 3 to 1 in our favour, and it looked as if we should win. Each side scored another goal before half-time, making the points 4 to 2 in our favour at the interval.

After changing over, Guy's did not keep up the form of the first half. The Weybridge team played to Ward, who time after time got away, owing to his pace, and was the means of adding 4 goals to their score in the second half, although he did not actually kick them all himself. Robson ought to have saved one, but failed to clear out of the goal mouth. German might have kept further back at times. Though several attempts were made nothing more was added to our score, and the game ended in a win for Weybridge by 6 goals to 4. Team:—

Guy's.—T. R. Wadson (goal); W. M. Robson, J. M. Brydone (backs); H. B. German, N. P. Shepherd, H. Bacon (halves); T. Edey, H. Barber, H. B. Wiltshire, Ed. Norton, T. A. Chignell (forwards).

REMARKS.

The play of the forwards would be considerably improved if Edey could get his passing more exact and centre much sooner, instead of taking the ball right down to the corner. Norton this year is not so good as last, and should put more dash into his play and possibly do a little more work. The outside left is one of the weak places of the team. Chignell is slow and is not quick enough with his passes. The half backs play a very strong game and feed the forwards well, but are inclined to pass out to the wings too much when in front of goal. Robson at back has played excellently this year and has been well backed up by Corfe, who it is a pity is not faster and more heavy. Brydone we hope will come on after some more practice. Wadson in goal has given some splendid exhibitions and is very neat with his hands, but seems to lack judgment when to run out and might make more use of the backs.

GUY'S 2nd v EWELL 2nd.

(Guy's, 2 goals; Ewell, 1 goal).

The above teams met at Honor Oak on Saturday, November 18th, and after a good game Guy's won by 2 goals to 1.

The ground was in a very soft condition and the ball consequently rather hard to manage. Ewell won the toss and elected to play with the wind at their backs.

The play for some time was very even, both sets of forwards attacking in turn, but at length Guy's got away and Lacy opened the scoring. Our forwards continued to have the most of the game and Rust scored with a good shot from inside right. Before half-time Ewell got through and beat Heap with a shot that gave him no chance.

Nothing was scored during the second half although our forwards repeatedly attacked. A minute before time the Ewell centre forward got clean away, and it looked as if he would make a draw of the game, but he finished by shooting wide, and left Guy's the winning team as stated above. Team:—

GUY'S.—E. T. Heap (goal): A. Leeming, J. Braithwaite (backs); P. V. C. Bent, D. J. Greenfield, P. P. Cole (halves); H. L. Dent, B. Rust, H. K. Lacey, W. D. Roberts, P. A. Peall (forwards).

GUY'S 2ND v. CENTRAL TECHNICAL COLLEGE.

(CENTRAL TECHNICAL COLLEGE, 3 GOALS; GUY'S, 2 GOALS.)

Played at Honor Oak on November 25th. Guy's, who were without several of the regular team, won the toss, but the College went straight down from the kick-off and scored, owing to a misunderstanding between the backs. The opponents continued to press, and after a time scored again, Braithwaite's head guiding the ball past Heap. Guy's were attacked, and after the arrival of an eleventh man had the best of the game, until the change of ends.

Eight minutes after the re-start Lacey scored, and several times the scores looked like being equalised. The College, however, again scored. During the last quarter of an hour Smith scored with a fine shot, and Lacey, Rust, and in fact each of the forwards, sent in shots which, with a little luck, would have scored. However, the game ended in the first defeat of the season by three goals to two.

The forwards never got together during the game, but Lacey, Dent and Rust worked well individually. Amongst the backs there was a great amount of miskicking. Morres worked hard, and Carter, who turned out as sub, also played very well. Team:—

GUY'S.—Heap (goal); Bennett, Braithwaite (backs); Morres, Smith, Carter (halves); Dent, Lacey, Langdale, Rust, Peall (forwards).

United Hospitals Hare and Hounds.

U. H. H. & H. v. WELLINGTON COLLEGE.

This match took place at Wellington on November 23rd, over a 7 mile course. The course was a difficult one, including many jumps and some very rough ground. For the first mile and a half the hospitals made the pace, after which four of our opponents went ahead and made the pace very fast, keeping in front till the end. They eventually won by 16 points to 39, the first man arriving home in 40 minutes. The order of finishing was as follows: E. H. Trousdale, 1; N. C. B. Furlong, 2; W. M. A. Foster, 3; W. H. O. Griffith, 4 (Wellington College); A. C. Birt, 5 (Hospitals): R. H. C. Birt, 6 (Wellington College); T. C. Mills, 7; R. S. Roper, 8; J. F. Robinson, 9; L. A. Mackley, 10 (Hospitals).

Solution of Case for Diagnosis, page 511.

A.C.E. was given. The sphincter ani was stretched. On pulling down the mucous membrane, a small ulcer one-eighth inch in diameter was found about two inches above the sphincter. It had ulcerated into a vein. This was ligatured, and hæmorrhage stopped.

From the Gazette's Special Pathologist.

E. R. M., HASTINGS.—Tubercle bacilli are present in the sputum in fair numbers.

J. E., MIDDLESBRO'.—No tubercle bacilli could be found in the sputum. The method adopted for transmitting the material is ingenious, but otherwise most objectionable, and besides entailing risk to those through whose hands the parcel might go, directly contravenes the Post Office regulations.

H. L. B., BUILTH.—Tubercle bacilli are present in the sputum in considerable numbers.

X. Y. Z., HASTINGS.—No tubercle bacilli could be found in this very purulent sputum.

G. M. J., ALTON.—Owing to this membrane having been placed in strong carbolic solution no growth was obtainable by cultural methods, but from coverslip preparations of the membrane we are justified in saying that bacilli are present which closely resemble the Klebs-Löffler bacillus. Re-examination of a swabbing from the infected area is advisable.

A. L. P., STREATHAM is advised to send a specimen of the urine, as this clot is dried up and useless for investigation.

PATHOLOGIST.

Births.

BURTON—BROWN.—On November 7th, at Via Venti Settembre, Rome, the wife of F. H. Burton-Brown, M.B., B.Ch., of a son.

HOWELL.—On November 8th, at Cleeve House, West Hill, Wandsworth, the wife of Thomas Arthur Ives Howell, of a daughter.

Death.

HICKS.—On November 18th, at Hendon, Henry Hicks, M.D., F.R.S., aged 62 years.

ED.—H. L. E.

Contents.

	PAGE
CONGENITAL HEART DISEASE: By Mr. H. S. French ...	521–527
PAPERS BY GUY'S MEN	527
APPOINTMENTS	527
HOSPITAL NEWS	527–528
A CASE OF ECTOPIC GESTATION OF SIX MONTHS.—DEATH. By C. J. Sells	529
NURSING NOTES	530
PASS LIST	530
PASSIM	531–533
CORRESPONDENCE: Mr. Handley replies	533
TWO INTERESTING CASES OF DISEASE OF TESTICLE ...	533–534
NOTICE	534
WITH THE ARMY MEDICAL CORPS IN SOUTH AFRICA: By Our Special Correspondent	534–536
IN LIGHTER VEIN	536–537
NURSING NEWS	537
METROPOLITAN ASYLUMS BOARD: Fever Instruction ...	537–538
REVIEWS	538
SPORT: Rugby Football—Blackheath v. Guy's and St. Thomas's; Guy's "A" v. Polytechnic "A"; Guy's 4th v. Streatham 4th; Guy's 4th v. Merchant Taylors' School 3rd. Association Football—Guy's v. Hampstead; Guy's 2nd v. Old Forresters 2nd. United Hospitals Hare and Hounds—United Hospitals v. Thames. Guy's Hospital Chess Club—Guy's v. St. Bart.'s; Guy's v. St. George's	538–540
FROM THE GAZETTE'S SPECIAL PATHOLOGIST	540
HOUSE APPOINTMENTS	540
DENTAL APPOINTMENTS	540

Notice.

All Communications, Articles, Letters, Notices, and Books for Review should be forwarded, accompanied by the name of the sender, to the Editor, GUY'S HOSPITAL GAZETTE, *Guy's Hospital, S.E.*

Any of our Subscribers who may be desirous of having their numbers of the GAZETTE *bound should leave them with the Librarian.*

The annual Subscription to the GAZETTE *is* 6s. 6d.; *post free,* 7s. 6d. *All financial communications, as well a subscriptions, should be sent to the Financial Editor,* Mr. C. H. WELLS, SECRETARY'S OFFICE, GUY'S HOSPITAL.

The charge for binding in blue, with the Arms of the Hospital in gold will be ONE SHILLING AND SIXPENCE.

Calendar of Coming Events.

December, 1899.

Sat. 16.—Messrs. Howse and Jacobson's take-in; Drs., H. G. Rashleigh and T. A. Matthews; Cl., J. F. Northcott.
1 p.m., Clinical lecture by Dr. Perry.
G.H.R.F.C., II.—London Irish, home.
III.—Hammersmith "A," away.
G.H.A.F.C., I.—Idlers, home.
II.—Plumstead, away.

Tues. 19.—Lectures cease.
Mr. Rowell's Demonstration on Anæsthetics, 12 noon.
Christmas Exam. in Anatomy, 1st and 2nd Year's Students.

Wed. 20.—Christmas Exams. for 1st and 2nd Year's Students begin.

Thur. 21.—Messrs. Davies-Colley and Symond's take-in; Drs., E. C. Bevers and E. G. Wales: Cl., H. A. Gaitskell.
First Half of Winter Session ends.

Mon. 25.—Christmas Day. Concert in Wards.

Tues. 26.—Boxing Day. Medical Office closed.

Thur. 28.—Messrs. Lucas and Lane's take-in; Drs., S. J. Ormond and N. F. Ticehurst; Cl., W. B. Secretan.

Guy's Hospital Gazette,

DECEMBER 16, 1899.

Congenital Heart Disease.

A Paper read before the Physical Society on Saturday the 9th December, by Mr. H. S. FRENCH.

MR. PRESIDENT AND GENTLEMEN,—Strictly speaking, the subject of my paper includes only those cardiac defects which are present in the heart at birth, and which are due to disease in utero. Another class of cardiac defects may be present at birth, and yet be due to no disease, but to either an arrested or a mal-development of the cardiac mesoblast. Clinically, the former group alone are held to be of interest; chiefly, perhaps, because subjects of the latter seldom survive birth long, and rarely reach adult life. From an embryological point of view, however, the hearts which show arrested or mal-development are of considerable interest, as stages comparable to those of fishes, reptiles, and other classes lower in the scale than man are found; moreover, it is not true that all patients with congenitally mal-formed hearts die soon after birth as one or two of these specimens will shew; and further, it is not absolutely certain what cases are due to disease and what to malformation. For example, atresia of the pulmonary valves is attributed to malformation; stenosis of the same valves is usually attributed to intrauterine disease. The existence of such disease, as distinct from mal-development, is in some hearts mere conjecture, in others the endocarditis has been superposed on mal-development; therefore, to complete the subject, congenitally mal-formed hearts will be included.

As an introduction to these a few words must be said about the normal development of the heart.

It originates as two separate tubes in the mesoblast of the lateral folds before these meet each other ventral to the embryo. When the lateral folds are complete, the two lateral tubes coalesce, at the end of the *second week* to form a single longitudinal tube. This tube has double walls, the inner endothelial and held by some to be derived from hypoblast, the outer muscular and mesoblastic. It is continuous in front with the two primitive aortæ, and posteriorly with the veins. In the *third week* constrictions appear, marking off aortic bulb in front, ventricular portion in the middle, auricular segment behind.

By the bending of the straight tube into an S shape, the venous and auricular portion comes to lie dorsal to and at a higher level than the ventricular.

At first the cavities are undivided and there is a single wide communication from auricle to ventricle; but during the third week, and before the appearance of any septa, a thickening of the endothelium on opposite sides of this auriculo-ventricular communication occurs, and

presently the thickenings meet across the middle line, so as to divide the auriculo-ventricular communication into a right and a left half (the future tricuspid and mitral orifices) and this is before the auricular and ventricular septa are mature.

Three distinct septa, however, shortly appear, namely an auricular, a ventricular, and a bulbar or *pulmono-aortic.*

1. The first of these to form is the *auricular.* It begins as a muscular and endothelial projection above, and in the *fourth week* grows downwards and forwards until it meets and joins the already formed partition between the tricuspid and mitral orifices described above. The last part of this septum to be formed is its lowest and anterior part, and here an aperture is sometimes found in cases of arrested development. At first there is no foramen ovale, but in the *second month* the central portion of the septum becomes thin and cribriform, supported on a muscular frame. In the *fourth month* the cribriform perforations have coalesced to form the single foramen ovale, and upon the left side of this, growing from above downwards, a valve appears, allowing the passage of blood from right to left but not from left to right. It is this valve which finally closes the foramen ovale, but not completely, as you know, until some months after birth.

2. Shortly afterwards the ventricular septum appears in the *fifth week.* This begins as a muscular and endothelial projection on the inside of the single ventricle near its apex. It grows upwards towards the base of the ventricle, and ultimately shuts off one side from the other. The process, however, is not very simple, and to understand it, it is first necessary to turn to—

3. The bulbar or pulmono-aortic septum. This starts at the distal end of the truncus arteriosus, and extends backwards towards the ventricles. It is rather a process of median constriction of the single tube into two, than the outgrowth of a regular septum, so that, as shewn in the diagram, each trunk comes to have three valves; in the one case one in front, two behind, in the other two in front and one behind.

One of these (the anterior near the heart, the left distally, owing to the spiral direction taken by the constricting process) is the pulmonary artery; the other is the aorta.

But the truncus arteriosus originally arises from the *right hand corner* of the ventricular cavity, and the two trunks into which it splits thus at first arise both from the right ventricle, neither from the left. In many cases of mal-development, this condition persists, and the left ventricle can only discharge itself into the aorta through an aperture in the ventricular septum, as seen in these three specimens.[1]

Normally, however, this is readjusted by the mode of completion of the ventricular septum.

The pulmono-aortic septum grows back beyond the truncus arteriosus, so as to project a certain distance into the ventricular cavity; its posterior extremity here fuses with an endothelial thickening at the lower free edge of the interauricular septum (this local thickening is the *septum intermedium of His*), and in this way cuts off the aortic trunk from the right ventricle, which still communicates with the pulmonary artery. The interventricular septum now grows up and fuses in a similar manner with this septum intermedium (which is the lower thickened end of the interauricular septum), and shuts off the two ventricular cavities from each other. This point of union of the septum intermedium with the pulmono-aortic septum on the one hand, and the interventricular on the other, is not muscular, and is the pars membranacea, or undefended space, where perforation usually occurs.

With regard to the ductus arteriosus, I need not go into detail about the aortic arches. There are five pairs of these, though recent writers describe six, and the pulmonary arteries are derived from the fifth or last pair. The original communication of the arch with the aorta is lost on the right side; but on the left side the fifth arch remains pervious as the ductus arteriosus up till birth, when it normally becomes obliterated, partly by loss of function, owing to the easier path for blood through the lungs; partly by the torsion which the great vessels undergo as the lungs expand.

Having roughly outlined the development of the heart, we will now consider defects which occur in each part of it separately. Any portion of the heart may for some reason cease to develop. If this were all, the heart would remain normal, except for arrested development in this part. But, when one part ceases to grow to its mature form, the other parts are thrown out of gear, and as a rule are compelled to grow abnormally, if the fœtus continues to live. This being so, it is seldom that a heart shews pure defects of arrested development, but as a rule other defects of mal-development as well, should the patient survive. When death occurs the heart may shew further defects due to acquired disease.

I. First, let us consider the auricular septum. This may be *entirely absent*, leaving a single auricular cavity like that of fishes. As a rule the heart is so defective in other respects, that the child does not survive, and I have no specimen to show you. Again, there may be a *partial* defect. Apart from the foramen ovale discussed below, the auricular septum may be imperfect or cribriform *above* the foramen, due to imperfect growth: this condition is rare.[3]

Or below the foramen ovale, the latter being present and well closed. This is due to non-union of the auricular with the ventricular septum by arrested development, and is generally associated with other shortcomings.[4]

1 Specimens—137950 (boy aged 16) and 138325 (boy aged 10). (both these again mentioned) and 138235 (managed 27).

3 Specimen—138482 From a man aged 35, with a loud bruit with the first sound and a fainter with the second. He had had symptoms only two years. There is only a thin rim of the auricular septum left, crossed by a few fine bands. Perforation as large as 5s. piece. R. V. and Pulmy. Art. IV. large; L. V. and aorta small. Blood probably went from *left* to *right* through auricular septum.

4 Specimen—137975 Deficient auricular septum below foramen ovale. Perforated pars membranacea, vegetations on all the valves. Pulmonary artery stenosed. From a girl aged 12 years, who had much cyanidis. Physical signs not mentioned.

Both auricles, in such cases, usually communicate with both ventricles, and with each other. It is, as this specimen shews, possible for patients with such to survive, without marked symptoms; the auricles are usually dilated, the ventricles normal, the pulmonary artery wide.

With regard to the foramen ovale, it is normally open at birth, and rarely closed for some months; the valve prevents blood crossing from left auricle to right, and the higher blood-pressure in the former prevents blood passing from right to left in the child as it does in the fœtus. No symptoms arise, and in a proportion of something like one case in five a more or less small chink persists. It is not uncommon to find complete patency of the foramen ovale without any other deformity, owing to non-development of the valvular flap; this may or may not cause a bruit synchronous with the auricular contractions heard at the base, and, by itself, causes no symptoms as a rule for example[5]. But most often it is associated with some other defect, the commonest being pulmonary stenosis discussed below; others, ill-developed left ventricle; ill-developed right ventricle; pulmonary atresia; aortic atresia; defective ventricular septum.

II. Next, with regard to malformations of the ventricular septum:

This may be entirely absent, when, if two auricles are present, we have the condition which is permanent in the frog[6]. The child may survive a few days or months, but seldom longer; and, as in the specimen, there are usually further defects of the great vessels and so forth also. Dr. Humphry, however, records a case in which a girl with a single ventricle, and transposed aorta and pulmonary artery, died at 16 from phthisis. The foramen ovale and ductus arteriosus were both closed, and there were no physical signs indicating the condition.

With regard to partial defects of the ventricular septum, three varieties may be described, all occurring near the base: namely

Those of the muscular part behind.

Those of the muscular part in front.

Those of the pars membranacea in between.

Of these the first is almost unknown. The second is uncommon, but there is here a specimen[7], shewing, not a perforation but a congenital aneurysm of the upper and anterior part of the muscular septum, bulging both into the right ventricle and into the right auricle.

Perforation of the undefended space is almost as common; and, as this space is normally small, defect in it almost always includes some defect in the muscular substance in front and behind as well.

It may occur as a simple arrest of development, without other malformation of the heart; in which case the aorta arises only to a small extent from the left ventricle, but largely from the right, either close to, or in common with, the pulmonary artery. There will, in such cases, usually be marked cyanosis, and a systolic bruit at the base, with a large right side, and all the physical signs of pulmonary stenosis except a thrill in the second left space.

More often, however, the defect is associated with pulmonary stenosis, whether due to disease or malformation; for, with pulmonary stenosis, either the foramen ovale or the septum ventriculorum must be open. A less common condition is that of aortic stenosis or atresia due to mal-development, when the ductus arteriosus is open as well. Patients with this defect might survive, but the condition is very rare.

Frequently the foramen ovale and the septum ventriculorum are both open in cases of pulmonary stenosis, or a perforation of the undefended space may be the only defect present.[8]

III. Thirdly, there may be defect in the pulmono-aortic septum, so that a communication, other than the ductus arteriosus, exists between the aorta and the pulmonary artery.[9] This condition is rare, and cannot, in life, be distinguished from a patent ductus arteriosus. The patient may survive to old age, if he escape phthisis; and there may be no symptoms. For physical signs there will be a loud bruit heard all over the precordial area, but chiefly at the left edge of the sterum in the second space; there may be a distinct thrill, and the right side of the heart will probably be hypertrophied. The bruit will not begin till after the systole has begun; it will be late systolic, and will run on into diastole. There may be a distinct thrill felt in the second or first left space. I am able to show you a patient to-night, aged 20, lately in Mary 14, in whom Dr. Goodhart diagnosed this condition; whereas Dr. Hale White was in favour of patent ductus arteriosus; Dr. Hale White said he had only seen three similar cases in his life, which shows the rarity of the condition.

Owing to its resemblance to the last condition, let us now consider the condition of defective closure of the ductus arteriosus. Such a condition may exist without

5 Specimen—1385 Foramen ovale partly open; no other defects. From a woman aged 29. No history. Also an unmounted specimen from a lady aged 55 who died of chronic Bright's disease, and had a large heart. Also had a ballooning, as you see, at the curtain covering, foramen ovale, with round aperture at the apex of the balloon. The latter is large as a walnut and bulges into R. A. so that blood went through L. A. to R. A. There were no symptoms of this in life.

6 Specimen—137925 (mentioned again under ectopia abdominalis) from a fœtus. Shews one ventricle below diaphragm, two auricles above; common origin of aorta and pulmonary artery. Patent foramen ovale.

7 Specimen—139626 From a man aged 35 who died of cerebral hæmorrhage. It was a case of Dr. Taylor's. and shows aneurysm of the ventricular septum, front part, bulging from left ventricle into both right ventricle and right auricle. There is no actual communication, and no sign of inflammation as the endothelium is smooth and healthy. The condition was regarded as congenital.

Also

Specimen—138250 From a patient aged 26 who died of erysipelas. Shows perforation from ant. sup. part of L. V. to R. A. It caused no symptoms. Ductus arteriosus, foramen ovale and undefended space all closed, and pulmonary artery healthy.

8 Specimen—138320 From a patient aged 45. No history. Large heart, especially right ventricle, which is loculated. There is a large perforation of the undefended space, but the great vessels are both normal.

9 Specimen—138220 Showing a round aperture of communication between the aorta and pulmonary artery close above the valves. There is no other defect. There was a loud, rough, systolic bruit at the base of the heart and all over the chest. There was much dyspnœa, but good nutrition. Patient died in five months.

any other deformity of the heart, and would then give rise to the physical signs just mentioned,[10] for example: if the opening were small, there might be no symptoms whatever; but with a larger opening, a greater mixing of the two blood-streams, more or less breathlessness on exertion and cyanosis would exist, and the patient's life would doubtless be shortened, and he would come to the doctor for treatment. The condition is extremely rare, however, by itself, and is more often associated with other cardiac defects. For example: a severe stenosis of the pulmonary valves arising from disease after the fourth or fifth intra-uterine month, when the ventricular septum was complete, would, if the patient were to survive, almost necessitate both a patent foramen ovale and a patent ductus arteriosus; that the lungs may be supplied from the left ventricle. Or, again, survival with atresia of the pulmonary artery could scarcely occur without a patent ductus.[11] And, on the other hand, cases occur of congenital atresia of the aorta in which the pulmonary artery supplies the systemic circulation through a patent ductus.[12] Patients with these deformities may live a few years, but are so severely handicapped that they rarely reach adult age.

Having considered the defects which occur in the septa, let us turn now to defects in the two great vessels of the ventricles. Hitherto the deficiencies have been entirely due to arrest of development, or to malformation; now another factor enters the field, namely, fœtal endocarditis. This factor has been invoked to account for most of the cases of pulmonary stenosis, but it is by no means certain how great a part it plays. If a patient with a deformed heart survives, it is agreed that endocarditis is especially liable to attack the abnormal valves; hence, at the autopsy, evidence of past inflammatory changes on them is common. It is possible, however, that the original stenosis may be due, not to fœtal endocarditis, but to a congenital malformation, in many instances. The evidence one way or the other is inconclusive.

However produced, the following are the chief varieties of defect:

First complete closure or atresia. This is not common, but may occur at three sites:

1st. At the valves themselves. Of this I have a specimen, No. [13].

2nd. On the cardiac side of the valves, the conus arteriosus. Of this no specimen.

3rd. On the distal side of the valves, in the trunk o the artery. Of this again a specimen.[14] The patients may survive a few months, but rarely longer; the condition necessitating patency of the ductus arteriosus, and either of the foramen ovale or the septum ventriculorum, or both. Next, partial closure or stenosis. This, next to an almost normal slight patency of the foramen ovale, is perhaps the commonest of all forms of congenital heart, and certainly the commonest in those who reach adult life. I show you one specimen only, number[15]. It is diagnosed in one of the cases I wish you to listen to to-night. The symptoms (cyanosis, clubbed fingers, and breathlessness on exertion), and the physical signs (large right heart, loud systolic bruit at base, and distinct thrill in second left space), you will then observe. The defect is usually attributed to fœtal endocarditis; and if the stenosis is severe, the ductus arteriosus remains patent, and either the foramen ovale or septum ventriculorum is perforated. In the latter case, owing to the mode of cardiac formation mentioned earlier in the paper, the aorta often remains in communication with both ventricles—more with the right than with the left. This is one of the factors, in addition to the pulmonary stenosis, leading to the large size of the right ventricle.

Thirdly, irregularities in the number and form of the valves. In pulmonary stenosis all three cusps are generally united at their margins to form a hollow truncated cone. But other irregularities may occur. Of these, perhaps the commonest is a bicuspid valve, consisting either of two equal cusps, or of a smaller and a larger, the latter showing signs of its formation by the union of two. Such a valve has a great tendency to undergo sclerotic changes, and lead to regurgitation.

Or again, there may be supernumerary valves, as

First. Three almost equal cusps with a fourth smaller one between two others.

Secondly. Four segments of almost equal size.

Thirdly. Three or four segments of nearly equal size with two or three smaller curtains interposed.

These date to the endothelial thickening which occurs previous to the division of the truncus arteriosus into pulmonary artery and aorta, and are of purely embryological interest, except in so far as such conditions predispose to endocarditis in after-life. I show you here several specimens.[16]

To turn to the aorta, congenital defects are here less frequent.

10 Specimen—138355 Patient who died at 28 of acquired heart disease. There is patent ductus arteriosus, but no other congenital defect. She was a seven months' child, and was delicate and had palpitations. There are recent vegetations and ulcerations of the aortic and mitral valves, but the pulmonary valves are healthy.

11 Specimen—138325 (Seen presently) from a boy aged ten.

12 Specimen—138040 (also seen presently again) from a child of nine months.

13 Specimen—1383 From a fœtus, shewing atresia of pulmonary artery with complete septum ventriculorum; right ventricle almost obliterated by hypertrophy; the foramen ovale not seen; the aorta arising from the normal left ventricle and communicating by ductus arteriosus with distal end of pulmonary artery.

14 Specimen—138325 Shewing pulmonary artery quite impervious; the septum ventriculorum deficient. The aorta coming chiefly from right ventricle. No ductus arteriosus, but lungs supplied by enormous bronchial arteries.
From a boy, aged ten, of precocious intellect, who suffered occasionally from cyanosis; had an intense systolic bruit between the shoulders, and died of pericarditis.

15 Specimen—138248 Shewing the funnel-shaped pulmonary valve. The foramen ovale is closed; the pars membranacea and the anterior muscular portion of the ventricular septum are widely perforated, and the right ventricle is hypertrophied. It came from a young adult, but there is no history.

16 Specimens—141317 Two pulmonary valves; one small, and the other large, equal to two. 141335 Four pulmonary valves unequal in size, healthy. And 141340 Four pulmonary valves, equal in size, and healthy.

Atresia is present in some cases, with atrophy of the left ventricle.[17] In such cases, if the septum ventriculorum is complete, the foramen ovale must be open, and allow the blood to pass from *left* to *right* instead of the other way. The right ventricle will be hypertrophied, the pulmonary artery wide, and the ductus arteriosus patent. Patients with this defect have survived a few days or months, but seldom longer.

Congenital stenosis of the aorta is very rare. Apparently if the aorta develops at all, it usually reaches a good size; atresia is commoner than atresia of the pulmonary artery; but stenosis infinitely rarer. I have, however, a specimen.[18]

Abnormalities in the number of aortic valves occur, and are similar to those described in the pulmonary artery, as one might expect. They may predispose to subsequent disease, but otherwise are of purely embryological interest. I have one specimen here.[19]

Having considered each part of the heart separately, I must now say a few words, but only a few, with regard to malformations of the heart as a whole.

In the first place, with regard to ectopia or external displacements. These are due to imperfect closure of the body wall, and are incompatible with life. The heart may be outside in the cervical, the pectoral, or the abdominal regions; and I would not have mentioned ectopia at all, except that I have here a specimen showing ectopia abdominalis, in a heart you have already seen as an example of single ventricle.[20]

Again, there may be malposition or transposition of the aorta and pulmonary artery, the auricles and ventricles lying in the normal position. The varieties of this defect are numerous, but almost all are incompatible with life beyond a few days or weeks. In nearly all cases the foramen ovale and ductus arteriosus are both patent; and the ventricular septum may be absent, defective, or entire. Specimen No. [21] shows one form.

Finally, I must mention complete transposition of the heart. This, though very rare, is of great interest, and is usually associated with complete transposition of the viscera, so that the heart apex is in the fifth right space, the liver in the left hypochondrium, and so on. It is of embryological interest, since Dr. Frazer suggests that the transposition may be due to the subject having been one of twins which were developed from a single ovum, and in which dichotomy was complete.

Having still a little time, I should like to say a word or two about the symptoms and physical signs of congenital heart disease in general, acknowledging that practically three forms only are found in adults, namely,

(1) Pulmonary stenosis with either patent foramen ovale or patent septum ventriculorum, along with patent ductus arteriosus.

(2) Simple patent foramen ovale.

(3) Simple patent ductus arteriosus, or pulmono-aortic septum.

A child suffering from congenital deformity of the heart is weakly, difficult to rear, and generally presents at birth, or soon after, signs of circulatory derangement. These are chiefly

1. Lividity or cyanosis, giving the name *morbus cœruleus*.

2. Paroxysms of dyspnœa and palpitation, with great intensification of the cyanosis, brought on by slight exertion, screaming, or exposure to cold.

3. Cerebral seizures and convulsions, often fatal.

4. Sometimes clubbing of fingers and toes.

The earliest and as a rule most definite symptom is *cyanosis*. It occurs in 90 per cent. Its causation has been much discussed, and several theories, none quite satisfactory, have been adduced. Such are:—

(1). *Mixing of arterial and venous blood:* but cases of single ventricle have shewn no cyanosis, and cyanosis may occur when there is no mixing of the blood-streams as in transposed vessels.

(2). *Extensive venous congestion:* this has been widely supported, and along with this view goes the clubbing of the digits.

(3). Deficient aeration in the lungs. In many cases this factor must come in, as only a part of the proper supply reaches the lungs. However, as in most discussions, it must be granted that none of these acting alone will cover all cases, and probably all three factors, perhaps with others, play a varying part in different cases. The *clubbing of the fingers* is usually later in its appearance than the cyanosis, but may be present when cyanosis is absent.

Certain *changes in the blood* have lately been recorded by Dr. Gibson, shewing considerable concentration. The red corpuscles may rise to 9,000,000, and the whites to 12,000, whilst the hæmoglobin reaches 110 per cent. or more. This is interesting in that a similar change occurs in dwellers of high altitudes, where, owing to the less tension of the atmospheric oxygen, aeration of the blood might be inadequate without such increase in its hæmoglobin and corpuscles. It would be interesting to make blood gas analysis upon subjects of morbus cœruleus.

With regard to physical signs in the heart, it is easier to detect presence of malformation than diagnose its exact nature.

On inspection the apex will as a rule be displaced outwards and will be diffuse and powerful.

On palpation a systolic thrill may be felt in the third or second left spaces in the case of pulmonary stenosis,

17 Specimen—138040 Shews congenital atresia of aorta. L. V. small but present, with a minute opening into inpendiculum of R.V. Large pulmonary artery, which, after giving off branches to the lungs, is continued through the ductus arteriosus into the distal part of the aorta. It came from a child nine months old, of whom no history is given.

18 Specimen—138464 From a woman, aged 25, who was delicate, but only occasionally cyanosed, and who died in child-birth. It shows an ill-developed aorta, with large pulmonary artery. Ductus arteriosus not shown, but ventricular septum perfect. Foramen ovale and post. super. auric. septum deficient, so that blood must have passed through it from *left* to *right*.

19 Specimen—141380 Shewing four healthy aortic valves of equal size, from a girl of 18 who died of cholera.

20 Specimen—137925 From a fœtus. One ventricle below diaphragm, two auricles above; common origin of aorta and pulmonary artery. Patent foramen ovale.

21 Specimen—138550 In which the aorta springs from R. V. which is large, and the pulmonary artery from a small L. V. The foramen ovale is cribriform, the ductus arteriosus closed, and the undefended space only minutely perforated.

and at a higher level (second and first spaces) in a patent ductus arteriosus, or at a lower level (fourth left space) in simple perforation of undefended space. The thrill, however, is often absent.

On percussion the cardiac dulness will be found enlarged, especially to the right, usually (in pulmonary stenosis) reaching even beyond the right border of the sternum.

On auscultation, there is commonly heard a loud, long systolic murmur, which can be traced with varying intensity over the whole precordial region, over the back of the chest, and widely conducted in all directions. This will almost always be loudest at the base to the left of the sternum. Its exact time, however, varies with the lesion somewhat. A simple patent foramen ovale would give a diastolic murmur running up to the systole. A patent septum ventriculorum, a systolic bruit lower in the chest; or perhaps no bruit at all. A stenosed pulmonary artery, a loud, long systolic bruit, with a thrill in the second left space. A patent ductus arteriosus, a late systolic bruit running well into diastole.

Of course, in any instance, there may be other bruits due to endocarditis after birth, superposed upon the congenital malformation.

The differential diagnosis is often impossible; at the end of the paper I summarise the symptoms and signs of three patients lately in the hospital, two of whom are here to-night for you to examine.

In forming a diagnosis no certain rules can be laid down, but one must in each case be guided by the collateral signs, the history of the patient, and the occurrence of murmurs on the right side of the heart.

Why the right side of the heart should be more often affected by endocarditis in utero than the left, is not easy to say. The right side has the most work to do before birth, as the left has afterwards. It seems that the part which undergoes most strain, is in each case that most affected.

As regards *duration of life*, there is considerable difference in the age attained in the various cases of cardiac malformation. Most of those with serious defect survive but a few days. In some, the mechanical difficulty of the circulation makes it impossible for life to be carried on for any great length of time, while in others with a considerable degree of malformation, the circuit through the heart and great vessels is sufficiently free for life to be maintained for years. Some have died of old age, having presented no symptoms whatever.

The duration of life in pulmonary stenosis depends partly on the degree of the obstruction; but more particularly on the condition of the cardiac septa. The prognosis is more favourable when there is some defect in the septum, as by this means relief is afforded to the overcharged right auricle and ventricle. In atresia of the pulmonary orifice, life is much more abbreviated, and will also depend mainly upon free communication between the two sides through imperfect septa. In a few cases the patients have lived for some time when the lungs derived their supply from vessels given off by the aorta.[22]

In transposition of the main vessels, the length of life is usually not great, but in some instances the patients have survived to adult life or even longer. With complete absence of the ventricular septum, the majority die in infancy, but a few have survived to adult age.

The *cause of death* in a large number of infants is due to *mechanical interference* with the circulation. A considerable number die of *convulsions*, *cerebral abscess*, *bronchitis* or pulmonary complaints. Those who live to adult age are peculiarly prone to pulmonary tubercle, in which respect they differ widely from patients with acquired heart disease, amongst whom phthisis is rare. Probably the majority of adults with congenital heart disease die of this complaint; or of cardiac failure, often due to superposed acquired endocarditis. Dropsy is comparatively rare. A septic endocarditis is occasionally engrafted upon the malformed valves or stenosed orifice.

Treatment therefore resolves itself mainly into prophylaxis against tubercle, brought on perhaps by over-exertion, or chills. The surface of the body must be carefully protected against cold, and a warm climate is desirable. Violent exertion, or over-exercise, bringing on palpitation and shortness of breath, must be absolutely forbidden, though in suitable cases the "Schott" treatment may be used to strengthen the heart and relieve dilatation.

In early childhood, especial attention must be given to the diet in order to support the patient's strength. Cod liver oil, extract of malt and iron, and syrupus trium phosphatum may be given at different times; and good nourishing food, avoiding sweets between meals, green apples, and anything which may upset the digestion.

In later life, any complications such as acute dilatation, anasarca, failing heart's action, must be treated as in ordinary cases of heart disease, by digitalis, strychnine, caffeine citrate, purges, diuretics, and so on as the case may demand.

Having come to the end of my paper, I should like to append short tables of the chief symptoms and physical signs in each of three cases of congenital heart disease, and then ask you to listen to the first two. The third* is the rarest variety, and has been quoted in the paper. I tried very hard to persuade the patient, a woman of 20, to come up to-night, but she refused, and I am sorry. But many of you may remember her in July last in Mary 14, under Dr. Hale White. The patients have to get home to-night, so I hope you will not keep them too long. They are as follows:—

1st. Thomas H., æt. 20. Under Dr. Taylor, April, 1899. Admitted for influenza. Physical signs and

22 Specimen—138235 Here it is not a question of patent ductus arteriosus, but the pulmonary artery is absent, and the aorto, arising from both ventricles, gives off two large pulmonary arteries. From a man aged 27, admitted for broken clavicle, and no cardiac symptoms; and 138325 A boy aged 10, where there is a tresia of pulmonary artery; and lungs supplied by hypertrophied bronchial arteries, already seen.

* This patient has finally promised to come.

symptoms:—Slight cardiac bulging, increased cardiac dulness, but not markedly to right. Diffused impulse, best in fifth space outside nipple, but also inside nipple line. Systolic thrill in second and third left spaces close to sternum. Loud systolic roaring bruit over pulmonary area, traceable up into neck, down to apex, and out into axilla; faintly heard on right side of chest, slapping second sound in pulmonary area. Marked cyanosis of face and hands. Nose and ears thickened; fingers clubbed. No dyspnœa or palpitation, except after violent exertion. Patient is a big man and strong. Diagnosis:—*Pulmonary stenosis;* and probably patent septum ventriculorum. (This patient came to the meeting).

2nd. Grace M., æt. 31. Under Dr. Taylor, October, 1899. Admitted for breathlessness and neuralgia. Physical signs and symptoms:—No cardiac impulse seen; no bulging. Systolic thrill over whole precordial area. Cardiac dulness not increased. Loud systolic bruit, best heard at sternal end of fourth left costal cartilage, and transmitted all over cardiac area. Also well heard behind at inferior angle of scapula. No cyanosis, but anæmia and pallor. Breathlessness on exertion, and blueness of lips. Slight clubbing of fingers. Nails anæmic. Diagnosis:—*Perforated ventricular septum.* (This patient did not come; it was too cold a night.)

3rd. Laura W., æt. 20, under Dr. Hale White, July, 1899. Symptoms and physical signs:—Large heart. At apex both a systolic and a diastolic bruit. These are attributed to acquired mitral stenosis and regurgitation after rheumatic fever. At base, a late systolic and diastolic thrill in the second left space close to sternum, transmitted up into first space. Along with this a loud rushing bruit, beginning late in systole, and running well on into diastole, heard best in the first left space near sternum, but also all over base of heart. No cyanosis, but florid complexion. No clubbing of fingers. Breathlessness only on exertion. Diagnosis: *Patent ductus arteriosus.* (This patient came all the way from New Southgate).

Papers by Guy's Men.

Four Cases of Otitis Media. By Vaughan Pendred, F.R.C.S. Eng.—*Lancet*, 18th November.

A Case of Adiposis Dolorosa. By W. Hale White, M.D., F.R.C.P., Illustrated.—*British Medical Journal*, 2nd December.

Appointments.

CIVIL.

STEVENSON, DR. THOMAS, has been appointed an Examiner at the University of Cambridge for the Diploma in Public Health.

NAVAL.

SURGEON GEORGE MCGREGOR, R.N., has been appointed to the *Caledonia*.

Hospital News.

CLASSIFIED LIST OF CASES.

"Clinical."

JOHN	1.	Pneumonia.
	2.	Pneumonia. Pericarditis. Empyema. Operation.
	3.	Pneumonia. Convalescent.
	4.	Hæmoglobinuria.
	5.	Pneumonia.
	7.	Pleurisy.
	10.	Appendicitis. Convalescent.
	12.	Chronic bronchitis.
	13.	Typhoid. Convalescent.
	14.	? Uræmia.
	16.	Pleurisy.
MIRIAM	17.	Pneumonia. Recovering.
	18.	Mitral stenosis and regurgitation.
	21.	Acute dyspepsia.
	22.	? Typhoid.
	23.	Pelvic abscess.
	25.	Cerebral tumour.
	26.	Gastric ulcer.
	27.	Hydronephrosis. (Nephrectomy).
	28.	Appendicular abscess. Operation.
	29.	Pyrexia.
	30.	Chronic bronchitis.
	31.	Stomatitis. Mercurial.
	35.	Broncho-pneumonia.
	36.	Marasmus.
Cot	33.	Diphtheria. Tracheotomy.
Cot	34.	Marasmus.

In the Surgical Wards.

CASES UNDER MR. HOWSE.

NAAMAN	2.	Necrosis of tarsus.
	3.	Ruptured varicocele. Early epididymitis.
	6.	Epithelioma of floor of mouth. Excised.
	9.	Varicose veins. Congenital cyst of neck.
	12.	Gonorrhœa. Urethral abscess.
	17.	Epithelioma of scalp. Excised.
DORCAS	1.	Dislocated head of radius.
	2.	Fistula in ano.
	6.	Spinal caries. Kyphosis.
	7.	Burns. Skin grafting.
	16.	Pre-patellar bursa.
ASTLEY COOPER	21.	Depressed fracture of skull.

CASES UNDER MR. DAVIES-COLLEY.

JOB	2.	Ulnar paralysis following injury. Operation.
	3.	Ulcer of lip. ? Epithelioma. ? Syphilis.

Job	4.	Morbus coxæ. Partial excision.
	6.	Rhinoplasty for syphilitic ulceration of nose.
	8.	Tuberculous testis. Castration (single).
	9.	Recurrent melanotic sarcoma of cervical glands. Excised.
	12.	Fistula in ano.
	22.	Periostitis of femur.
Lydia	4.	Myeloid sarcoma of tibia. Amputation through thigh.
	6.	Gutter fracture of vault, producing traumatic meningocele.
	7.	Movable kidney.
	9.	Rickety curved tibia. Osteoclasm.
	10.	? Chronic osteitis.
	14.	? Tuberculous knee.
	16.	Carcinoma mammæ. Amputation.
Cornelius	14.	Colloid carcinoma in omental inguinal hernia. Contusion of abdomen.
	15.	Sub-conjunctival hæmorrhage. ? Fractured base.
	19.	Compound fracture of tibia and fibula.

Cases under Mr. Lucas.

Lazarus	3.	Varicose veins.
	16.	Cellulitis of leg.
	20.	Ventral hernia.
	21.	Epithelioma of floor of mouth.
Martha	1.	Tubercular gland in parotid. Operation.
	3.	Large abscess in thigh. ? Cause. ? Lipoma.
	7.	Bead in ear.
	9.	Iliac abscess.
	15.	Fractured tibia and fibula.
	16.	Rickety deformity of femora.
	17.	Early hip disease.
	18.	Glands in axilla. ? Septic from cut on finger.
	21.	Fibroid tumour of uterus.
Astley Cooper	1.	Fissured fracture of frontal bone.
	7.	Fractured base of skull. ? Fractured spine.
	31.	Comminuted compound fracture of arm. Circular amputation.

Cases under Mr. Golding-Bird.

Luke	5.	Retained testis.
	6.	Abdominal tumour. Exploration. Matted omentum.
	7.	Talipes equinus.
	8.	Multiple ulcers. Tubercle and syphilis.
	13.	Subdeltoid abscess.
	15.	Necrosis of sternum after typhoid.
	19.	Renal calculus.
	21.	Inguinal hernia.
Charity	6.	Recto-vaginal fistula.
	7.	Tubercular knee.
	8.	Tibia and fibula. Fractured.
	10.	? Sarcoma of femur.
Charity	11.	Tubercular hip
	13.	Fracture through surgical neck of humerus.
	16.	Carcinoma recti.
	17.	Lipoma over ribs.
	20.	Suppurating gland in groin.
	21.	Carcinoma mammæ.
	23.	Ankylosis of elbow. ? Gonorrheal.
Cornelius	1.	Fractured external condyle of femur.
	2.	Fractured patella.
	3.	Dislocated lower epiphysis of femur.
	7.	Lacerated arm. Amputation. ? Fractured bone.
	12.	Ruptured biceps of arm.
Astley Cooper	4.	Fractured olecranon.
	5.	Fractured tibia and fibula.
	20.	Supra-condyloid fracture of femur.
	22.	Fractured ribs. Comminuted fracture of humerus.

Cases under Mr. Jacobson.

Dorcas	21.	Cleft palate. Hare lip.
	22.	Cyst in neck.

Cases under Mr. Symonds.

Job	14.	Hæmaturia. Horse-shoe kidney. Symond's operation.
	15.	Loose semilunar. Excised.
	16.	Excision of elbow.
	17.	Stricture of œsophagus. Symond's tube.
	18.	Epistaxis.
Lydia	19.	Ulnar nerve paralysis.
	20.	Goître. Right lobe excised.
	21.	Tubercular knee. Amputation.
	22.	Movable kidney. Symond's (Langenbeck) operation.
Patience	3.	Umbilical sepsis. Pectoral abscesses. Incised.
Samaritan	8.	Periostitis of tibia. Incision.

Cases under Mr. Lane.

Lazarus	11.	Ununited fracture of humerus. Operation. Wired.
	14.	Old dislocation of elbow. ? Tubercular.
Martha	10.	Tubercular caries of rib.

Cases under Mr. Dunn.

Luke	1.	Inguinal hernia.
	2.	Epithelioma linguæ.
	3.	Psoas abscess.
	4.	Sarcoma of upper extremity of tibia. Secondary to sarcoma of foot.
Charity	2.	Epithelioma vulvæ.
	3.	Carcinoma mammæ.
	4.	Chronic synovitis of knee.
Cot D.		Septic arthritis of both knees.
Patience	1.	Acute suppurative arthritis of knee. Amputation.
	2.	Facial erysipelas.

A Case of Ectopic Gestation of Six Months.—Death.

By C. J. Sells, M.R.C.S., L.R.C.P.

A woman, aged 29, was admitted to the Surrey County Hospital in September with the following history:—

She menstruated last in February and March, the periods lasting nine days. The loss was scanty and light coloured, as was usual with her. During the following months vomiting was frequent, more often after food. Nine weeks previous to admission, whilst getting up one morning, she was seized with violent pains across the lower part of her abdomen. She vomited frequently and burst out into a profuse perspiration, also losing consciousness. She continued in much the same condition for a fortnight, the pain at times passing off but returning in a few hours with great severity. The vomiting increased in frequency, and the abdominal pain became more severe about six weeks before admission. During the whole time her bowels were obstinately confined, and she took no solid food. Two days before admission, she had an attack of pain and vomiting similar to her first attack, and lost consciousness.

Pregnancies.—One, resulting in a miscarriage at the third month, in December, 1898. She kept her bed for ten days, but continued to lose blood for several weeks.

Previous illnesses.—None; patient had always been healthy and strong.

Condition on admission.—Patient is somewhat emaciated, very anæmic, and in a partially collapsed condition. Pulse, 144 per minute; temp. 98·6° F.; resp. 20. The abdomen is distended and tense. At the lower part of the abdomen, and extending upwards to about an inch above the umbilicus, there could be felt a large mass occupying this region. The mass was fixed, dull on percussion, and no fluid thrill obtainable. The left side of the abdomen was fuller and more prominent than the right, and markedly more tender on palpation. To the right of the median line and extending upwards from the symphysis pubis for about three inches, there was an elongated prominence, harder than the larger mass, and apparently adherent to it. Both flanks were resonant. On auscultation a loud souffle, synchronous with the pulse, could be heard an inch below and to the left of the umbilicus. No fœtal heart sounds could be heard.

The breasts were enlarged, hard and knotty, no fluid could be squeezed from them, but the nipples were capped with a few brawny scales. No secondary areolæ were visible. The patient was a blonde.

Per vaginam.—The os uteri was close down to the vulva, patent, and two fingers could be introduced for three inches. Posterior lip was swollen and œdematous, the anterior being thin and flaccid. In the region of Douglas' Pouch an elastic swelling and a large mass could be felt filling up the left side of the pelvis, and apparently continuous with that in the region of Douglas' Pouch. The cervix moved with the abdominal mass. The uterus could not be made out. No sound was passed. The rectum was loaded.

Treatment.—Morphia was given, and the vomiting kept in check by means of Tinct. Iodi mi., administered at intervals. Simple and oil enemata were employed to clear the rectum, with but small result. Nutrient enemata and suppositories were given alternately every two hours. Brandy was given by the mouth. Patient became weaker, and on the early morning of the third day after admission, diarrhœa set in and became continuous. A little later patient suddenly became pulseless, and died.

Post-mortem Examination.—On making an incision through the abdominal wall it was found that the parietal layer of peritoneum was adherent to the abdominal contents. The mass felt inter vitam was found to consist of two portions, an upper and lower. The upper portion was formed by a large blood cyst, the walls being composed of transverse colon and coils of small intestine matted together. Its cavity was filled with blood clot, some of which (about one and a half pints) being fairly recent and the rest partially discoloured and adherent to the intestines.

The lower portion consisted of two parts, one in the left iliac fossa, and one nearer the middle line. This latter portion was the body of the uterus, somewhat enlarged and its cavity, which measured two and a quarter inches in length, was lined with a distinct decidua. The cervix was much elongated, the internal measurement being four and three-quarter inches. The anterior wall was extremely thin, the posterior very œdematous. Both the external and internal os were patent. A probe could not be passed along either Fallopian tube from the uterus. By dint of careful dissection the left tube was traceable for about two inches over the upper surface of the second mass, when it became lost. The right broad ligament and contents were normal.

The second part of the lower mass consisted of the left broad ligament, greatly distended, enlarged and adherent at the sides to the pelvis and above to the blood cyst. On incision, about two pints of thin blood-stained fluid escaped, and a large, well-developed fœtus was to be seen lying in the cavity. The amnion was intact, and the placenta adherent to the right lower part of the posterior wall. This was easily detached except for an area of about two inches, which was only got away by tearing through the layer of fibrinated clot forming a part of the wall of the blood cyst, thereby causing a free communication between the two cavities. The *right ovary* contained a corpus luteum, healthy but probably not recent. The *left ovary* could not be found, but the fibrinated extremity of the tube was discovered, and a probe passed along for about one and a half inches. *The rectum* was displaced to the right, and constricted at the brim of the pelvis so as to admit the forefinger only.

The fœtus was 12½ inches in length, plump; the skin was not wrinkled. On the hands and feet the skin peeled off easily. The hair was dark and covered the scalp, eyebrows present, eyelids were partially adherent to one another. The sex was distinct, the fœtus being female. Nails soft and reached half way to the tips of the fingers.

Nursing Notes.

Among the nurses quite the excitement of the month is the news of the departure of two of our Sisters to South Africa. They are so anxious to go, we cannot be but pleased that they are going ; from all other points of view it is our loss.

All of those who had previously applied and had their hopes dashed by the decision of the War Office have begun to hope again ; quite half of us are keen on going out, and probably we all imagine ourselves appointed to go to the front when in all fairness the best positions must be given to army nurses, civil nurses being content with work at base hospitals and outlying posts.

However, nothing much better could be asked for a civil nurse than to work on a hospital train and under the big surgeons, the posts which have been allotted as the particular duties of our two Sisters.

People are never quite happy without a grievance, and all the nurses at the hospital hug to their hearts a grievance, that of the "good old times," but from different points of view.

The nurse of the old régime is never tired of telling of her days—the days when there were no two half-days and a whole day off in every month, the time when we were permitted no services in other churches, when we had the same chaplain morning, noon, and night, day in day out ; when there was no comfortable meal for night nurses out of the ward, when all *pros* must need be cooks or obtain scowls from the staffs if at 4 a.m. they had not prepared an interesting meal. The good old time when food in the dining hall was obtainable only by a barbaric scramble, when all children's clothes were washed and ironed in the ward in addition to the ordinary work, when *pros* weren't spoken to quite like human beings, and only spoke when they were spoken to. When to fall ill was at the very least a lack of tact. Nurses who have known and suffered all these joys look gloomily on the new style of *pro*, utter melancholy prophecies as to the kind of nurse they will make, and regale them with tales of the snubs *they* suffered and the prodigies of work *they* performed.

On the other hand, the present day *pro* is sick to death of hearing of these same old days, especially when the moral at the end is applied to herself, and heartily wishes the old nurses could be relegated to the society of the Dodo, and brag to him of what they did. For while they gloat over the terrors of the past, they won't own that the influx of new nurses adds in the least to their comfort : and they would like the inhabitants of the Nursery to believe that it was a much happier time when they worked till their backs ached, and their heads were splitting, and they cried themselves to sleep over the rank injustice of the staff nurse, and when one fluctuating and uncertain half-day a month was the longest off duty time.

Can we expect the *pro* of to-day to ardently long for the return of these joys, or to demand to be given more work ? Is she to turn out a poor, limp, half-hearted nurse because she is asked to compress a little less work in the twenty-four hours, because she is not asked to press her nose quite so tightly to the grindstone or because she is spoken to as a lady. Still we do think that sometimes there is a little too much of "That-is-not-my-work" spirit about them, that there might be a little more deference to the head nurse, and not such a caving in for a simple head-ache.

We think the following description of peritonitis overheard in an accident ward most refreshing :

17. Say, 19, my little gel don't look as if she'd 'ad peritoneetis, does she ?

19. No, wot is it ?

17. Why a bad pain in the stomach, and when it reaches the 'art you dies.

Astonishment on the part of 19—and others.

Pass List.

University of London, October, 1899.

M.B. EXAMINATION.

Examination for Honours.

Medicine—Second Class.—C. T. Hilton.

Forensic Medicine—Third Class.—C. T. Hilton, G. N. Meachen, P. Turner.

Passim.

The work for medical men at the war is commencing in earnest these days. As will be seen from Mr. F. E. Fremantle's letters from Capetown, as long ago as three weeks back the work at such a distant base hospital as Wynberg was none too light, and with the recent heavy losses on the British side the Army Medical Corps will have its hands full. Every day more Guy's men are going out. Mr. R. B. Stamford left for South Africa last week, and Lieutenant Evans, R.A.M.C. is to leave next week.

Meanwhile we have to correct an error which we made concerning Surgeon Beadnell, R.N., in the last number of the Gazette. His brother writes to us to state that we were labouring under a misapprehension. We took it that Surgeon Beadnell landed with the Naval Brigade at Durban, and went with them to Ladysmith. As a matter of fact another Naval Brigade was landed from the *Powerful* under Commander Ethelston and Major Plumbe of the Marines. Surgeon Beadnell landed with this latter force, and accompanied them first to Stormberg and then to Modder River, under Lord Methuen's command, where he is still apparently stationed. From all we hear Surgeon Beadnell and his colleagues will have their hands full.

The Nursing Staff at Guy's will also be worthily represented on the field. Sister Lilian (Miss Tippetts) leaves next week, and will take up her nursing duties immediately upon arrival. On January 6th, Sister Stephen (Miss Creighton) leaves to take charge of the Red Cross Ambulance train which is to be named after Princess Louise, and which will run to and fro from the front to the base hospitals at Wynberg, East London, Port Elizabeth, and Durban. The berth on this train will be by far the most interesting post for a nurse in the whole war, and Sister Stephen is envied by all the other nurses who are going out. It is comforting to reflect that Guy's will be so worthily represented in such an important post.

On Monday last the second of the series of addresses on the "Religio Medici" was given in the Hospital Chapel by G. W. E. Russell, Esq. Possibly many men did not realize that Mr. Russell is the author of that most interesting of recent books "Collections and Recollections," besides being universally acknowledged to be one of the best speakers of the present day. There was a comparatively small attendance, and only those who were present could realize what the others had missed. We hope to publish Mr. Russell's address in the next number of the Gazette.

It has always been a proud boast of Guy's men that we are one of the few hospitals in London where there is no Resident Medical Officer in the Surgery, and where the responsibility lies entirely upon the House-Surgeons and House-Physicians on duty. The value from the educational view is immense, and the burden of responsibility turns out better men than any other system, and it is the earnest wish of the majority of those in authority that the occasion for the appointment of a permanent Resident Medical Officer may never arise. The day of his appointment will see the last of one of Guy's most time-honoured traditions.

We have preached before now, and possibly may have preached too often, of the very serious responsibility which weighs upon all who work in the Front Surgery. The students and the outside public there meet face to face, and any negligence or misunderstanding meets a speedy retribution in the shape of newspaper reports and coroners' inquests. Every thinking man who is made a resident—and we are proud to think that the Guy's residents are a match for any other hospital—fully realises his responsibility and is a better man for the knowledge. Of residents it is not our intention to speak. What we wish to impress upon dressers and ward clerks in the front and back surgeries, is that it cannot be allowed for a moment that they should hold any position of public responsibility. The house-surgeon or house-physician on duty is the sole responsible representative of the hospital. Light-hearted and casual dressers, the more ignorant the more confident, have no right to saddle other people with the responsibility of their failings, and often take too much upon themselves. Any resident would much prefer to do more work in the knowledge that he is only responsible for what he has seen himself, than that he should do less work and accept the responsibility for those who are unfit to hold it.

We do not suggest for a moment that anything has occurred which should call for these remarks, but dressers, full dressers in the Front Surgery especially, often seem to forget in to

what glaring publicity they may bring themselves and their responsible officers, if they in the endeavour to keep a clear surgery, shirk or scamp their work.

Suggestions as to the working of appointments in this hospital are usually excluded from the Gazette, but we think there is not the slightest doubt in the minds of the majority here, that many men get the appointment of full dresser who are quite incompetent to do it. It is a very difficult thing for the authorities to always be sure of their man, but we think that a few more extensions for both full and assistant surgeons' dressers might better the situation.

With the coming week Christmas preparations begin in real earnest. Sisters, dressers and ward clerks will be working from morning till eve, decorating for all they are worth, and nigger rehearsals and such like matters will leave no spare time. With customary kindness and courtesy, all the great piano firms in London have renewed their yearly loan of instruments, and firms of all kinds are helping by generous offers for the Christmas tea. Whilst this spirit is so much abroad outside the hospital, it would be a matter for regret if men actually working within the walls of the hospital forgot their duty to the place to which they owe so much. We would especially remind men who are not in the wards that heretofore it has been customary for *all*, irrespective of position or work, to help the Christmas Fund with their subscriptions. Half-a-crown or five shillings is a small sum to pay, and those who are asked to do this have none of the burden of actual decoration, or the other countless and unceasing labours of the men who forego a home Christmas for a Christmas at the hospital. Those who do nothing owe it to their consciences as Guy's men to help with subscriptions the men who do the work.

Christmas this year will run on much the same lines as usual at the hospital. The Residents will give the annual Nigger Entertainment in all the wards on Christmas day, and the following week will be given up to Ward Concerts at the average rate of three a day. Out-patients' is being rapidly fitted up with electric light to make it brighter for the Christmas Children's Tea, probably the biggest and best undertaking of the whole year. Altogether there will be no rest for the Residents now till the old year is out.

As a supplement to the Gazette this Christmas, we are issuing a reproduction of a black and white view of Hunt's House (the Medical Buildings) by Mr. William Hyde, the well-known illustrator of London scenes. The picture was drawn expressly for the Gazette with the idea of giving men a lasting remembrance of a part of the hospital which is so eminently characteristic as the Medical buildings. With the eye of an artist, Mr. Hyde has conceived the hospital in its most attractive light, making a fine suggestive picture out of much grimy, unpromising material.

The combined team from Guy's and St. Thomas's Hospitals suffered a severe defeat at the hands of Blackheath this year, and there seemed a lack of keenness about the game which was quite contrary to precedent. Guy's was represented by nine players, and St. Thomas's by six, several of the Westminster men being unable to play at the eleventh hour. At the same time we do not quite agree with our contemporary, who writes:—"The fixture is a time-honoured one; but it is a pity that during later years the students have fallen off lamentably, and have seldom given their rivals a good game." We might point out that last year the combined team were victorious, while the year before Blackheath won by the narrow margin of one try, and the Hospitals only just missed scoring on several occasions, so that if our rivals did not have a good game during these years, the fault did not rest with the medicals. This year, though the game was fast and at times interesting enough, there was a great want of that dash and decision which usually marks a hospital team; the men with few exceptions did not tackle well, and though the forwards on the whole played well they lacked dash.

We had hard luck in being again beaten last Saturday, as, though only able to put a weak team in the field, they played well, and just missed making a draw with Croydon, who won by two tries to one (6 points to 3). Harrison played a good game at full back, and when he has gained confidence should be a useful player. The halves, Louisson and Brown, also did well. O'Brien had the misfortune to sprain his ankle in the second half, and we were in consequence materially weakened. It is doubtful if the

ground will allow of a game against the London Scottish to-day, for though, owing to some misunderstanding about dates, the fixture is not printed on the card, it holds good. We hope that though our side is still not representative, as Sime, Cutler, Jackson and O'Brien will be absentees, the remnant of the team will acquit themselves worthily, and that those who are not yet permanently included will, by their keenness, justify their selection.

With this number, another year ends for the Gazette. A year of much dull, but honest work in the hospital. It is hard work in these times of great outbursts of charity in other directions, to keep the crying needs of the hospital before the public, and get any adequate return. We are glad to know, however, that the flow of money into the hospital coffers, if slow, is still steady, though we are a long, long way from being out of the wood.

With regard to the Gazette: we are probably open to a charge of being at times unnecessarily dull and too prone to the easy task of giving advice, both practical and moral. If we have erred in this direction it is only due to a heartfelt wish to impress upon all men at Guy's what a great place this is where they are spending the best years of their life, and to urge them under all circumstances to remember who they are in their relation to the public, and to play the man while at the hospital. In conclusion we'll wish everybody within the walls of Guy's Hospital,

A Merry Christmas and a Happy New Year.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Mr. Handley Replies.

Dear Sir,—I find that many of the Dental students, to whose kind feeling I owe the handsome gold cigarette case of which I was lately the happy recipient, are no longer about the hospital. May I therefore beg a few lines of your space to convey to them my sincere thanks for a present which is very valuable in itself, but which I value infinitely more as a token of the givers' goodwill and appreciation. May each of them have all good luck in the future!—I am, dear Sir, yours very truly,

21, The Common, W. S. HANDLEY.
Woolwich, S.E.,
December 12th, 1899.

Two Interesting Cases of Disease of Testicle.

A. B., aet. 35 years, contracted syphilis about six months before admission, for which he was treated; apart from this complaint he has always enjoyed good health. Patient gave the following history of his case—he had a hydrocele on the right side three years ago which was tapped at the same time as a radical cure for a right inguinal hernia was done.

Two weeks ago he found a swelling on right side of scrotum which rapidly increased in size; he consulted a medical man who put a trocar and cannula into it, but only drew off a little blood-stained fluid; his medical man afterwards sent him to hospital as a case of acute hydrocele.

On admission, there was a hard right-sided scrotal swelling which was tender to the touch; the cord was quite free, the epididymis could not be felt separate from the testis; it was not translucent nor was it fluctuating, it was regular and smooth in outline. Hot lead and opium fomentations were applied and Iodide of Potassium gr. xxx with ʒi. Liq. Hydrarg. Perchlor. t.d.s. and the bowels were well opened with a brisk purge. The swelling continued to increase in size till it became about the size of an orange and extremely painful, necessitating the giving of morphia; it also became more tender but showed no signs of breaking down; the anti-syphilitic treatment was continued for three and a half weeks, but as the swelling continued to increase in size and on account of the extreme pain and tenderness, the testicle was removed.

The wound healed up well and the patient was discharged four weeks after the operation.

Mr. Targett, who kindly examined the specimen, reports as follows:—The testis is undoubtedly gummatous, and it is interesting to find such hyaline thickening of the sheaths of the seminal tubules in syphilis, etc.

C. D., æt. 36, a purser on board a pleasure steamer was admitted in October last, having been sent up by a medical man as a case of strangulated hernia. He gave the following history:—Neither testicle has ever properly descended, but he could always feel them, each being just external to the spine of pubes, his sexual functions are normal. He never suffered any inconvenience from the misplaced testicles till March, 1899. At that time he noticed the right testicle was a little larger than the left; it was slightly tender. He paid little attention to this and went on with his work; the swelling, however, gradually increased in size, and became so painful that he was obliged to leave off his work in October, 1899. One day, about this time, he was seized with an attack of vomiting and suffered great pain in the site of swelling. A medical man was called to see him and diagnosed his case as one of strangulated hernia, and sent him to the hospital.

On admission, patient stated his bowels had not been opened for five days, in spite of taking purges. He

appeared to be in a great deal of pain; he had vomited, but not after admission into the hospital. The swelling, which was situated over the inner half of Poupart's ligament, was regular in outline and fairly well defined. The fingers could get above the swelling, separating it clearly from the abdomen. It was not translucent, there was no impulse on coughing, and it was dull on percussion.

It was somewhat tender to the touch, but two distinct parts could be made out—one a hard portion which felt like the testicle, considerably enlarged; and the other a soft fluctuating portion which ultimately proved to be blood. There was no history of injury or of syphilis. Anti-syphilitic remedies were given for a short period without any good effect, and so it was thought advisable to explore the swelling, and, if necessary, remove the tumour.

A.C.E. mixture was given, and the swelling cut down on; a large amount of blood of a dark colour escaped; also several fragments of fungating-looking material. The testicle, which was surrounded by more of this fungating mass was removed, and the wound well washed out, and the skin stitched up—it all healed up by primary union and the patient was discharged.

Mr. Targett, who kindly examined this specimen, reports as follows:—

The retained testis is enlarged by a soft spongy new growth, which was developed in the centre of the body of the testis and ruptured with the tunica vaginalis. There is no evidence of invasion of the vas deferens or spermatic cord.

The separate mass is a portion of the fungating tumour. Histologically the growth is a chondro-carcinoma, small nodules of cartilage being visible among the alveoli of the carcinoma, which is of the tubular, columnar-celled type.

MONTAGUE H. WAY.

Royal Portsmouth Hospital.

Notice.

ROYAL COLLEGE OF PHYSICIANS OF LONDON
AND THE
ROYAL COLLEGE OF SURGEONS OF ENGLAND.

Diploma in Public Health.

Notice is hereby given that the two parts of the next Examination in Public Health will commence on the following dates, viz.:—

Part I., January 1st, 1900.

Part II., January 8th, 1900.

A candidate intending to present himself for either part of the Examination must give fourteen days' notice in writing to the Secretary, at the Examination Hall, Victoria Embankment, London, W.C., from whom all particulars relating thereto, including the Regulations and Syllabus of the subjects, may be obtained.

FREDERICK J. HALLETT,

November 21st, 1899. Secretary.

With the Army Medical Corps in South Africa.

(By Our Special Correspondent.)

No. 1 General Hospital,
Wynberg, Cape Town,
Wednesday, November 15th, 1899.

We, on the Roslin Castle, left Las Palmas on November 1st, to the sound of "The Soldiers of the Queen," and cheers from H.M.S. Niobe, which was stationed there on guard over the trooping squadron. However, despite her presence, we were ordered in a most mysterious way to put all lights out on board that evening; the watch was armed, and our course was changed so that we sailed some miles outside the usual track, were not sighted at Cape Verde, and lost several hours accordingly. It appeared that a suspicious-looking torpedo boat, made in Germany for some South American Republic, had been lying up at Las Palmas for some weeks, with forty spare men on board and without obvious reason, and that she was intending to sail from there on the same evening as ourselves. The captain of the Niobe let us go on alone and unprotected, but considered it advisable for us to veil our movements in this extraordinary way in case the suspected boat might be in the pay of the Transvaal Goverment. However, nothing further occurred; and after fleeing from Mr. Kruger's navy for three days, we resumed our normal state, and reached Cape Town uneventfully on Wednesday night last.

Table Mountain is a most satisfactory bit of geography; and the Devil's Peak by its side is equally worthy of its name. Cape Town is a long straggling line of buildings about a quarter of a mile deep, facing north, and separating the said devil and the deep sea. The suburbs extend in a line round the base of the Peak; so that we at Wynberg, although ten miles out by train, are only just at the back of Table Mountain, and are magnificently situated on its lower slopes, with a fine view southwards over the flats to Simon's Town and False Bay. Our place consists of row upon row of long, single-storied, wooden huts with windows on both sides, and a verandah all along the southern side. Each hut contains two wards of twenty-five beds each, with an orderly-room and offices between them.

There are at present about 400 patients in; but there probably will be 1,000 when they come to fighting from this side of the Republics; and in addition, No. 2 General Hospital is to be stationed in our grounds, and to be under canvas. Our buildings constitute in peace time the permanent barracks, but they are certainly very well adapted for their present use. My own cases have been entirely on the medical side, mostly heat-cases, dysenteries, agues and rheumatism, invalided before they got near an enemy, and now for the most part packed off homewards on the Sumatra which sailed to-day. We have about half-a-dozen typhoids, and I contemplate being inoculated, as a scientific experiment. The surgic

cases are for the most part slight, and the wounds have all healed without suppuration, so far. The only operations since we arrived, so far as I know, have been an amputation of the finger, and an operation to-day for traumatic aneurism of the third part of the axillary. The latter was done this morning by Colonel Stevenson, P.M.O. on the lines of communication, Professor at Netley, and author of the most recent book in English on Military Surgery. He decided not to ligature the subclavian, but to cut down, turn out the clots and ligature the two ends of the artery. The operation went off very well, and under the circumstances the methods were good; but why the P.M.O. on the lines of communication should have done an operation in our hospital, it is impossible to say.

We are just expecting 87 wounded Boer prisoners, who have been kept rolling about outside the harbour in the Patiala, because it was too rough to land them yesterday and to-day. Now that the hospital ships Spartan and Trojan are at work, we expect to get some of the more serious cases. I hear that Rogers of Johannesburg was at the permanent hospital in Cape Town, and is now off with the South African Light Horse to the front; Davis is medical officer to the Imperial Light Horse at Ladysmith, and Hamilton was staying on in Johannesburg to the last moment, and so may be in Ladysmith with Davis, or anywhere else.

Tuesday, November 21st.

The chief excitement of the week here has been the arrival of eight wounded Boers, eight out of the eighty taken at Elandslaagte, and shipped here from Durban last week. The rest are on the Penelope in Simon's Bay, about due south of here; we get a fine view of it in the distance, with a long range of mountains running down to it on either side, and the dull homogeneous green flats with their bright white sand-hills and houses stretching between us and the bay.

The Boers are not particularly interesting from a surgical point of view, except that field-cornet Pretorius with a fractured patella from a gun-shot, tumbled down yesterday, and seems to have a hæmarthrosis in consequence. The poor dear old man is a typical Boer, and is so convinced of English villiany, that he refused any operation whatsoever—wiring had been proposed—as the English doctors would be sure to cut off his leg, or worse, so soon as they got him under chloroform. Oom Carl, or whatever they may call him, is just what one expects a Boer field-cornet to be, a rough, sturdy-looking man, of vast weight, and with a large brown beard, jovial and friendly with us now, but properly suspicious of everything ordered for him. As a fact, the authorities in Cape Town have given special orders for the Boers to be treated luxuriously, and, as a result, they are given the very choicest diet, and every conceivable extra that the hospital can produce, with tobacco and cigars free, fruit, flowers, basket-chairs, cushions and newspapers of all opinions. In fact, they, our prisoners, get a considerably better time of it than our own soldiers and N.C.O.'s, who have bled for the right cause. Mr. C. J. Pretorius has mingled with his patriotism the sincere and absolute belief in the Divine Right of Boers, a very real religion, however insincere it may seem to the Englishman. Mr. Jan Botha, on the other hand, a young attorney, typifies the new generation, clever and up to date, with at least an outward reverence for the Ooms; but a mixture of Boer traditions with the new civilization, a blend which is less artistic than the pure native product. To say more would be personal; but everyone who wants to know anything about South Africa, should read an excellent little novel called "Prinsloo of Prinsloosdorp," and he will be not only a wiser, but a merrier man.

Of the 400 odd patients now in this hospital, a very considerable number are a floating population of slight medical and "specific" cases, many overlooked at home in the primary medical examination, who are shipped here immediately on arrival, and probably will never go to the front. A colleague and I share the medical work, and in the "serious" ward I get an interesting experience of ague, dysentery and simple continued fever, besides a few enterics. Soon, however, we hope, having seen enough for the present of these things, to hand over all the medical cases to No. 2 General Hospital, which is to be established here under canvas (W. J. Hancock is, I believe, on the staff of No. 2); while we get the surgical cases, which will probably begin to crowd in upon us in a month's time.

Even at present the surgical cases, although shipped down all the way from Durban, only when able to stand the voyage, are of extreme interest. I cannot publish the cases at length as the men looking after them have taken endless trouble with them and will be publishing them later on if they can get permission; while the *Lancet* reporter has made some very cool suggestions as to the rules of the service prohibiting us from publishing, so that my colleagues might as well give him their notes on the cases. However, you may as well know that one of my colleagues has eight cases of bullet wounds traversing the lung—a wound hitherto considered fatal from hæmorrhage—all of which are recovering; that he has one case of a bullet passing right through the abdomen from before aft and out behind, with hæmatemesis and melæna, which has now recovered; that another case has recovered after a bullet passed in at his left sacro-iliac joint and out at the right hypochondrium; that another man was shot through the bladder, had hæmaturia, and is now well except for slight pain along the track of the wound, and pain in micturition; and finally, that a man is practically well after having had a bullet wound from just below the zygomatic arch on one side to just below the outer orbital process on the other with subsequent epistaxis and bleeding from the ear. Mr. Makins, who has just been round here with Sir William MacCormac, thought it very likely that there had been a fracture of the base in this case.

We are simply over-run with official visitors. Others are not allowed at present. We don't mind Sir William MacCormac's and Mr. Makin's visits, in fact, we enjoy

them and shall probably find them very useful. They come simply as visitors and not officials. But when the authorities, medical or combatant, come from Cape Town, we are kept hanging about all the afternoon with nothing to do, on the off-chance of their visiting our wards; and they never come near the medical side.

No 4. Stationary Hospital is here at present, waiting to go up to De Aar, and not the least of them is Lieutenant H. Simpson, R.A.M.C. He tells me that Lieutenant Humphry and Lieutenant Onräet are both in the country. F. E. F.

In Lighter Vein.

WHAT WE SHALL COME TO; OR CHRISTMAS IN 1959.

It was Christmas-time, and an old man was walking, or rather tottering slowly along St. Thomas's Street. The pavement was slippery, for it was freezing hard, and the local authorities (to wit the newly created municipality of Maze Pond) had failed to sweep away the half frozen snow. This, be it observed, was due to the fact that the new Lord Mayor of Maze Pond was in his private capacity a road conservator (or as it used to be called crossing-sweeper) and press of public duties at the new municipal buildings in "The Terrace" had rendered it impossible for him to give much time to his private affairs. The old man consequently slipped, and falling in the classical manner on his over-extended hands, did the correct thing in fractures. He was of course taken to the hospital and a sympathetic ward clerk in endeavouring to establish beyond a doubt that the patient's family history had no direct ætiological bearing on the injury, discovered that the old man was a former student in the hospital.

"Yes," he said, "I used to be a student here, but I haven't made a success of private practice. When I was a student the examination system which has since been done away with was in full force. It doesn't matter to me much who knows it now, so I may tell you that when I was here I took my M.B. and B.Ch., the M.R.C.P., and F.R.C.S., and afterwards went on to the M.D., the M.Ch., and the D.P.H."

"That sounds bad," said the ward clerk, but I know such things used to be done. Why, one of our surgeons is said to be an L.S.A. now, but of course he doesn't own to it."

"When the change came," said the old man, "I was in practice; but I found that my patients were leaving me, and most of them went to a man who had just put up his plate, and who let it be known that he had been ploughed six times for the M.D. Nebraska. Of course I couldn't compete with a man like that. I moved to another part of the country and tried to keep my past career a secret."

"Did you manage it?" said the ward clerk, as he hammered the last French nail into the old man's ulna, which had been cut down on under a local anæsthetic, and was now in position on the aseptic carpenter's bench in the surgery.

"No," replied he, "a local practitioner got hold of an old copy of the Register at a second-hand book shop. He spread the facts of my past life about and ruined my little practice."

"Those must have been odd times," said the clerk, as he planed down a little projecting angle of bone. Then with a few dabs of aseptic glue he fastened up the wound and took the arm out of the vice. "By the way, as you're an old Guy's man, wouldn't you like to see round the place?"

So saying he led the way into a large building labelled "Superintendent's Office." A large number of men with various trucks, carts, and barrows, were busily engaged outside manipulating bundles of evergreens, lanterns, and flags. Inside all seemed confusion.

"Who is that?" asked the old man, pointing to a heated gentleman in his shirt sleeves, who seemed to be directing affairs.

"Oh! that's the Superintendent," replied the clerk; "he's awfully busy just now with the Christmas decorations. They used to be all done by the Residents and Junior Staff, but uow they're always too busy, so the Full Staff have taken it on."

"Have those extra bundles of holly come yet?" the Superintendent was heard asking. "Dr. Druggem was down here asking for them just now—and, by the way, Mr. Kutdown says he wants another ladder; he can't reach the upper rails in Lazarus with the one he has now."

Just then Mr. Kutdown came in. He was evidently in a great hurry, but he stopped to speak to the Ward Clerk.

"I was so sorry I couldn't come round with you this afternoon," he said apologetically. "You see these decorations take up so much of one's time."

"Oh, never mind," replied the clerk, "I know how busy you are. Besides, we only made a short round this afternoon." The clerk then led the way to the wards, which were approached by a patent lift. The lift was not, however, in working order, as a holly-berry had

got into the machinery. At last, however, they reached a medical ward by an inclined plane—that also was slightly out of order owing to the numbers of lights, lanterns, etc., which were piled along it. The ward was a scene of the utmost activity. Sister and the nurses were busy cutting up aseptic draperies. Physicians and their assistants were putting up wires and hanging lanterns. All the beds had been removed, and their places filled by "cosy corners," Japanese screens, and other artistic devices.

"You don't seem very full," said the old man, "I suppose you never have many patients at Christmas-time."

"Oh," said the clerk, "They are all arranged for. You see, the Superintendent manages it all, and so he transfers all the patients to Isolation, and the strong room, or the museum, or anywhere where there's room."

They passed on to the Private Room at the end of the ward, from whence strange sounds were issuing.

"Here," said the clerk, as he opened the door, "Are the visitation staff. They are rehearsing for the Christmas Day entertainment. They always do a nigger show for the students on Christmas Day. But I am afraid I must leave you," he said suddenly. "I have my 141st minor operation on at 5 o'clock. How will you get on outside? Would you like to come in for Christmas? I daresay I could get you a shakedown in the theatre."

"No, thank you," replied the old man. "I have something to go on with. You see, they pensioned me off when I reached the age limit during the Transvaal War; but that's all I've got now."

"Well, good-bye. Hope you can find your way out."

He couldn't, but eventually reached a disused dynamo in a cellar, where he sat and thought on the changes at Guy's.

B.

Nursing News.

MATRON'S OFFICE.

On Saturday last, December 9th, Sister Stephen (Miss Creighton) was appointed by the War Office, as a member of the Army Nursing Reserve, to the post of Superintending Sister of the new Hospital train, now being built in Birmingham, and which will be dispatched to South Africa on January 6th. Sister Stephen will be with us over Christmas, and will leave on one of the first days in the New Year.

Sister Lilian (Miss Tippetts) is also going to South Africa, and will probably leave England on the 23rd instant. Fuller information will be given in the next number of the GAZETTE.

Nurse C. A. Warren, Head Nurse in Lazarus Ward, who has been with us over three years, left on December 9th, to take up an appointment as Private Nurse on the Continent.

Probationer Overbury has been appointed Head Nurse in Lazarus Ward.

Nurse Mann, who left us about a year ago, and has since been a pupil at the School of Tropical Medicine, and passed their examinations, has received an appointment as Sister in the Government Hospital at Lagos.

Miss Denyer has left us at the end of her year's training as Lady Pupil, and shortly proceeds with her sister to Umtali, Rhodesia, where she has been appointed Nurse in the European Hospital.

Metropolitan Asylums Board.

FEVER INSTRUCTION.

NOTICE TO STUDENTS.

A course of instruction in the diagnosis and treatment of fevers will be held at each of the undermentioned hospitals on Tuesdays and Fridays (except at the Brook Hospital) at the times stated below, commencing Tuesday, 9th January, 1900.

EASTERN HOSPITAL, The Grove, Homerton, N.E., at 12.15 p.m. E. W. Goodall, M.D., Medical Superintendent.

NORTH-WESTERN HOSPITAL, Lawn Road, Hampstead, N.W., at 12.15 p.m. W. Gayton, M.D., Medical Superintendent.

*WESTERN HOSPITAL, Seagrave Road, Fulham, S.W., at 12.15 p.m. R. M. Bruce, M.R.C.S. Medical Superintendent.

BROOK HOSPITAL, Shooters Hill, Kent, at 2.30 p.m. J. MacCombie, M.D., Medical Superintendent (N.B. – The class at this hospital will be held on Mondays and Thursdays, commencing January 8th).

PARK HOSPITAL, Hither Green, Lewisham, S.E., at 2 p.m. R. A. Birdwood, M.D., Medical Superintendent.

SOUTH-EASTERN HOSPITAL, Avonley Road, New Cross, S.E., at 12.15 p.m. F. M. Turner, M.D., Medical Superintendent.

*SOUTH-WESTERN HOSPITAL, Landor Road, Stockwell, S.W., at 2 p.m. F. Foord Caiger, M.D., Medical Superintendent.

FOUNTAIN HOSPITAL, Grove Road, Lower Tooting, S.W., at 2.15 p.m. C. E. Matthews, M.D., Medical Superintendent.

The classes at the hospitals marked * are full.

The next course will commence in May.

N.B.—Students desiring to attend a course of instruction, must, *before* attending at the hospital, bring (between 11 a.m. and 4 p.m., Saturdays 11 a.m. and 12 noon) or *send by post* to—

The Clerk to the Metropolitan Asylums Board, Norfolk House, Norfolk Street, Strand W.C.

(1) Authority from the Dean of the Medical School.

(2) Fee—£3 3s. for two months' course, or £4 4s. for three months' course. Cheques to be made payable to—"The Metropolitan Asylums Board."

*** The student must *definitely* ascertain *before* taking out his course whether he requires a *two* or a *three* months' course. In the event of his taking out a three months' course, the extra £1 1s. will not, under any circumstances, be refunded to him.

(3) Full name and address, and name of medical school. (N.B.—The name must be in full, and must be distinctly written.)

(4) A list of the above hospitals, arranged in the order in which the student would prefer to attend, in case the classes at any of the hospitals should be already full. At least two names should always be given.

By order, T. DUNCOMBE MANN,
Clerk to the Board.

Reviews.

Orthopœdic Surgery : A Text-book of the Pathology and Treatment of Deformities. By J. Jackson Clarke. (Cassell and Co.).

This very useful and practical little book opens with a definition of the word "Orthopœdy." A word often passes into general use, the origin of which remains very obscure, and such is the case with the word Orthopœdy. It was first used by Audry in his treatise entitled, "L'Orthopédie du l'Art de prevenir et de corriger dans les Enfants les difformités du Corps," published in 1757, and is not as is sometimes supposed, used to express any special association with the deformities of the feet, but deals with deformities generally.

Orthopœdy is quite a modern branch of Surgery, and anything like a systematic compilation of its various parts may be considered to be the work of the present century. It was in the seventeenth century that the Compractrios flourished, a band of wanderers who existed by buying children for the express purpose of deforming them, and then reselling again to the various European Courts as curiosities to amuse and divert the silly and the idle. The art these ruffians practised was the antithesis of Orthopœdy, and has been ably described for us by Victor Hugo in his "L'homme qui rit."

The opening chapter of Mr. Clarke's book deals with the question as to how much should be left to the instrument maker and how much a medical man ought to know and feel responsible for in reference to an instrument which he may order for the patient. The author rightly insists on the practitioner knowing not only the needs of the patient but whether the instrument meets those needs.

Tubercular disease of the spine is fully and ably described, and the author sums up the question of forcible correction of the angular deformity under four heads, and seems to be of the opinion that the case is "Not proven."

Those cases of osteo-arthritis first described by G. F. Still, occurring in children, are mentioned and Mr. Still's original paper quoted. The book is quite up to date, well printed, and freely illustrated, and should attain a wide popularity among students.

Sport.

Rugby Football.

BLACKHEATH v. GUY'S AND ST. THOMAS'S.

(BLACKHEATH, 19 POINTS; GUY'S & ST. THOMAS'S, NIL).

This match, played at the Rectory Field on the 2nd instant, turned out rather disastrously for the combined team. The Blackheath Club were able to put a fairly strong team in the field, and were evidently determined to wipe out last year's defeat; this was, indeed, not a difficult matter, as owing to late scratching on the part of our sister hospital, the combined team was decidedly weak. The weather was dull, and the turf greasy, the game being in consequence of a somewhat scrambling description, although, at times, the passing of the Blackheath three-quarters was brilliant, and occasionally the Hospitals' forwards brought off some good rushes. Blackheath resorted to the Welsh tactics of centring from the wing with a high kick in front of the goal, and they scored in this way on two occasions; Patch having hard luck in his efforts to save the first of Skrimshire's tries, as he ran foul of the post. In the first half play was rarely out of the Hospitals' quarters for any considerable time, and tries were gained for our opponents by Skrimshire (2), Todd and Forest, Bullock converting the second and fourth, so that at half-time the home side led by 2 goals and 2 tries to nil.

Changing over, the Hospitals' team showed much improved form, and by means of successful scrimmaging and good forward rushes, they attacked pretty frequently, but never looked really dangerous. Jameson, who for his weight played a very plucky game at half, considering the skill and experience of the Blackheath pair, damaged his shoulder rather severely, and was at a disadvantage during the remainder of the game. After successfully preventing further score up to the last minute, a pretty bout of passing ended in Forrest just getting over wide out, and as no goal resulted, the final score stood:—Blackheath, 2 goals and 3 tries (19 points); Hospitals, nil. Team:—

HOSPITALS.—B. Patch (back); L. F. Hanbury, A. O'Brien, E. Morgan, F. W. Sime (three-quarter backs);

A. D. Jameson, C. D. Pye-Smith (half-backs); R. C. Mullins, D. H. Trail, T. P. Thomas, K. V. Trubshaw, A. E. Martin, R. J. C. Thompson, G. A. Weir and P. Manson (forwards).

GUY'S "A" v. POLYTECHNIC "A."

(Guy's, 12 points; Polytechnic, 8 points).

Played at Merton, and resulted in a win for Guy's by 4 tries to 1 goal and a try. The chief feature of the game was the very medium play of the forwards, who seemed to have quite forgotten the art of packing. The game was finished in darkness. Harrison played well at back. Team :—

Guy's.—E. M. Harrison (back); D. P. Watson, H. N. Grose, R. W. Allen, C. A. E. Ring (three-quarter backs); J. T. Hicks, S. C. Brown (half-backs); M. A. Collins, R. G. Lawry, A. R. Thompson, F. W. Featherstone, R. G. Anderson, G. Nunn, —. Beaumont, A. W. Gater (forwards).

GUY'S 4th XV. v. STREATHAM 4th XV.

(Streatham, 9 points; Guy's, nil).

Played at Streatham on December 2nd. Guy's started with three men short, and finished with only ten, two more having to retire owing to injuries. D. W. Smith played a good game at back, his tackling being especially safe. Team :—

Guy's.—D. W. Smith (back); D. Steele-Perkins, G. Russell, E. H. Wyand (three-quarter backs); P. F. Minett, H. Wallace (half-backs); H. S. Jones, R. Felton, J. D. Pearson, M. J. Rees, E. H. Adams, H. D. Smart (forwards).

GUY'S 4th XV. v. MERCHANT TAYLORS' SCHOOL 3rd XV.

(Guy's, 21 points; Merchant Taylors' School, nil).

Played at Honor Oak Park on December 6th, and resulted in an easy win for Guy's. The forwards opened the scoring, and tries were subsequently obtained by Reinhold, Kynaston, Steele-Perkins and Palmer, two of which were converted by Beattie and one by Marshall. Team :—

Guy's.—G. H. Sherris (back); C. H. Reinhold, D. Steele-Perkins, G. Russell, H. S. Palmer (three-quarter backs); A. E. F. Kynaston, H. Wallace (half-backs); —. Beaumont, F. A. Beattie, A. C. Dickson, R. P. Marshall, L. Doudeney, J. J. Jardine, H. S. Jones R. Felton (forwards).

Association Football.

Guy's First Eleven have not had much of a time during the last fortnight, as two out of their three matches have been scratched. Kenley, last Saturday, scratched owing to their secretary having made a mistake in his fixture card, and Eastbourne on Wednesday, December 13th, were obliged to cancel the match owing to the inclemency of the weather. At the time of writing also the prospects of our match v. The Idlers on Saturday next, does not appear to be strikingly good, but we hope that the ground will be in condition when the day arrives.

GUY'S v. HAMPSTEAD.

(Guy's, 5 goals; Hampstead, 1 goal).

Played at Honor Oak Park on Saturday, December 2nd, when a late start was made. Hampstead at first began to press, and scored a goal soon after the start. Guy's up to half-time played a marvellously slow game, but managed to equalise by Shepherd, who put in a good shot. On changing over, our forwards got better together, and being well backed by the halves, pressed Hampstead the whole time. Goals were scored by Wiltshire, Lacey, Edey and Chignell. Wiltshire played a hard and good game, but the rest of the team did not rise to his form. Team :—

Guy's.—R. Wadson (goal); W. M. Robson, J. M. Brydone (backs); H. B. German, N. P. Shepherd and H. Bacon (half-backs); T. Edey, H. K. Lacey, H. P. Wiltshire, F. B. Manser and T. A. Chignell (forwards).

GUY'S 2nd XI. v. OLD FORRESTERS 2nd XI.

(Guy's 6 goals; Old Forresters, 1 goal).

Played at Honor Oak Park on December 9th, and despite the excellent condition of ground and weather, a poor game resulted. Roberts started the ball for us with the wind, and play settled down round our opponents' goal-posts. During the first half we managed to net the ball four times. After the change we scored twice, and our opponents once, the final score being 6–1 in our favour. Morris (2), Chignell (2), Roberts and Lacey scored for us. Robson played a useful game for our opponents. Team :

Guy's.—E. P. Heap (goal); A. Leeming, J. Braithwaite (backs); B. B. Rust, H. B. German, A. Barber (half-backs); H. H. Dent, H. K. Lacey, W. O. Roberts, F. Morris, T. A. Chignell (forwards).

United Hospitals Hare and Hounds.

UNITED HOSPITALS HARE AND HOUNDS v. THAMES HARE AND HOUNDS.

This match was contested last Saturday at Roehampton over a five and a half mile course, and resulted in an easy win for the Thames by 15 points to 40. The Hospitals were poorly represented, and did not expect to do much against such a strong team as the Thames turned out. The order of arrival was as follows:—H. G. Lloyd (Thames), C. V. Grill (Thames), J. B. Sharpe (Thames), A. L Rye (Thames), F. Colmar (Thames), T. C. Mills (U. H.), R. S. Roper (U. H.), R. M. Barron (U. H.), R. E. Brayne (U. H.), L. S. H. Glanville (U. H.)

Guy's Hospital Chess Club.

GUY'S v. ST. BART'S.

This match was played at home on November 29th, and resulted in a win for Guy's by 4½ points to 1½.

Guy's.		St. Bart's.	
Mr. Dismorr	½	Mr. Parker	½
„ Kitchin	1	„ Letchworth	0
„ Kennard	½	„ Hughes	½
„ Stewart	1	„ Shrubsole	0
„ Russell	1	„ Pridham	0
„ Parrott	½	„ Lloyd	½
Total	4½	Total	1½

GUY'S v. ST. GEORGE'S.

This match was played away on December 8th, and resulted in a win for for Guy's by 7 points to 1.

Guy's.		St. George's.	
Mr. Dismorr	0	Mr. Christian	1
„ Kitchin	1	„ Albert	0
„ Kennard	1	„ Turner	0
„ Stewart	1	„ Lock	0
„ Russell	1	„ Bond	0
„ Parrott	1	„ Powell	0
„ T. Robinson	1	„ le Fleming	0
„ Faulks	1	„ May	0
Total	7	Total	1

From the Gazette's Special Pathologist.

W. E. T., Nottingham.—The substance of the cervix uteri is very dense, and its surface is partly covered with papillary outgrowths or "erosions." There are no evidences of malignant disease.

T. D. M., Hoddesdon.—No tubercle bacilli could be found in the sputum.

G. E. H., Ramsgate.—The wall of this cyst in the breast is composed of dense fibroid tissue, with atrophied glandular lobules. It is lined with young inflammatory growth, but there are no signs of malignant disease.

E. B. R., Boston.—Tubercle bacilli are present in the sputum in very small numbers.

A. L. P., Streatham.—Reaction, acid; Sp. gr., 1029; Albumen, a decided trace; blood, a minute trace; sugar, absent. *Microscopical examination.*—This specimen separated urates freely. These were redissolved by warmth and the urine then centrifugalized. The deposit so obtained is somewhat scanty, but contains a fair number of hyaline casts, some of which appear granular from adherent urates. No crystals were found, but a few spermatozoa were seen. There is a small number of red blood discs present, but it is only after prolonged search that we are able to state that any epithelium is present. Such cells as there are may possibly be renal epithelium, but owing to their characters being obscured by adherent urates we cannot give a definite opinion. The result of this examination tends to confirm our suspicion that the kidney is at fault. The diagnosis seems to lie between a misplaced kidney (against which is the freedom from pain) and an embedded calculus, *i.e.*, a calculus in the substance of the kidney; *not* a calculus lying in the renal pelvis. This supposition appears to be the more likely, but it would not be wise to rely absolutely on the result of two examinations. PATHOLOGIST.

House Appointments.

The following recommendations for appointments have been made by the Medical Committee:—

House Physicians.—Messrs. H. L. Eason (Dr. Taylor); A. H. Carter (Dr. Pitt).

Assistant House Physicians.—Messrs. J. G. Taylor, A. E. Clarke.

House Surgeons.—Messrs. G. S. Simpson (Mr. Lucas); F. W. Brook (Mr. Golding-Bird).

Assistant House Surgeons.—Messrs. L. Wilkin, H. A. Gaitskell (Front Surgery); C. B. Thomson (Mr. Jacobson); E. E. Parrett (Mr. Symonds); E. M. Brown (Mr. Lane); D. P. Watson (Mr. Dunn).

Obstetric Residents.—Mr. A. R. Thomas (Jan. 1st); Mr. R. H. J. Swann (Feb. 15).

Dental Appointments.

The following appointments have been made by the Treasurer upon the recommendation of the Dental Council:—

Dental House Surgeons (for six months, from January 1st, 1900).—Messrs. J. Black, H. T. Campkin, F. J. Pearce.

Assistant Dental House Surgeons (for three months, from January 1st, 1900).—Messrs. R. C. G. May, S. L. Prall.

Demonstrators in the Conservation Room (for six months, from January 1st, 1900).—Messrs. F. W. Bromley, J. J. Jiménez, H. J. Webb.

Birth.

DODD.—On November 21st, at 14, Goldstone Villas, Hove, Brighton, the wife of Arthur H. Dodd, L.R.C.P. Lond., M.R.C.S. Eng., of a daughter.

Marriages.

CARTWRIGHT—GILES.—On December 7th, at St. Mary Abbots, Kensington, by the Rev. Walter P. Smith, assisted by the Rev. R. A. Waddilove, Ernest Henry Cartwright, M.A., M.D., barrister-at-law, of 1, Bower Terrace, Maidstone, son of the late Sir Henry Cartwright, of 1, Courtfield Gardens, S.W., to Dorothy, youngest daughter of the late Richard W. Giles, Esq., of 60, Nevern Square, S.W.

SMITH—PULLIN.—On November 22nd, at St. Augustine's, Honor Oak, Walter H. M. Smith, L.R.C.P. Lond., M.R.C.S., eldest son of Dr. Smith, Croydon, to Florence Emily, daughter of Joseph Shurly Pullin, of Honor Oak.

Death.

JACKSON.—On December 4th, at 6, Scotch Street, Whitehaven, Thomas Jackson, M.D., aged 65.

Ed.—H. L. E.